TESTIMONY ON RURAL HEALTH

THURSDAY, MAY 7, 2015

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:03 a.m., in room SD–124, Dirksen Senate Office Building, Hon. Roy Blunt (chairman) presiding.

Present: Senators Blunt, Moran, Cochran, Cassidy, Capito, Murray, and Schatz.

OPENING STATEMENT OF SENATOR ROY BLUNT

Senator BLUNT. The Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies will come to order.

We're glad to have all of you here this morning. I want to thank the witnesses for appearing before the subcommittee today to discuss the unique healthcare needs that face rural communities.

We have two panels this morning. Members should know that I expect to call up the second panel around 11 a.m., so we have adequate time to hear from both. Of course, if for some reason we get done with this panel earlier than that, we will go to the second panel quicker. But we will try to go to the second panel no later than 11 o'clock.

We are glad that everybody has come today to help us talk about this issue. Certainly, one of the priorities of the committee and one of my priorities in Congress has been to ensure that all Americans have access to quality and affordable health care in their local communities, regardless of where they live.

The obstacles faced by rural healthcare patients and providers in rural communities are unique and often significantly different from those in urban areas. I'll be at the Truman Medical Center in Kansas City tomorrow, and they have a whole different set of problems, but they have some unique problems, too. Both our inner-city hospitals and our rural hospitals have challenges that are unique to them.

In rural healthcare, the issues can range from lack of access to simple primary care physicians to difficulty finding specialists. As a result, many patients have to drive long distances to receive care or simply just may not seek care until it is too late.

This creates unnecessary disparities in healthcare not found in other parts of the country and ultimately costs taxpayers more in Medicare expenditures than if we would've provided access in a

better way. I think it is critically important that Washington recognize that healthcare access is essential to the survival and success of rural communities across the country.

I am concerned that some of the proposals within the department's budget and recent regulations that have been issued that would just disproportionately affect rural healthcare and jeopardize healthcare access and, in fact, when you do that, you really threaten the survival of small towns.

The Medicare payment system often fails to recognize the unique circumstances of rural or small hospitals. And this administration has appeared, in my view, to target rural hospitals, in particular.

For example, the department once again has proposed to decrease the reimbursement rate for critical access hospitals and eliminate critical access hospitals within 10 miles of any other hospital. The department has proposed that change for years, yet just recently has been able to provide details to Congress about which hospitals would be eliminated if we look at that new mileage standard.

The department has continuously issued regulations that would disproportionately affect small and rural hospitals more than their larger urban counterparts. CMS's abrupt enforcement of the 96-hour condition of payment for critical access hospitals and the direct physician supervision rules and recovery audit contractor audits not only hinder the care of patients but consume significant amounts of medical staff time and resources to comply with those rules.

Finally, given the fact that the department requested a $4.1 billion increase for the coming fiscal year, it is even more surprising, or maybe not so surprising, that the Office of Rural Health received a $20 million cut in the proposal that the administration issues. The administration, in fact, has never once asked for an increase in rural health programs.

More than 46 million Americans live in rural areas and rely on rural hospitals and other providers as their lifeline to care. They face ongoing challenges in assessing proper medical treatment while rural healthcare providers are overwhelmed with Federal rules.

Certainly, Senator Murray and I both have an interest in this. I look forward to working with her and the rest of the committee to ensure that all Americans, regardless of where they live, have access to affordable health care.

Senator Murray.

STATEMENT OF SENATOR PATTY MURRAY

Senator MURRAY. Thank you, Mr. Chairman, for calling this hearing on such an important topic.

I'm very pleased to welcome all of our witnesses who are here today, but I'm particularly excited to welcome Julie Petersen. Julie is the Chief Executive Officer of the PMH Medical Center in Prosser, Washington. Through her work at PMH and her leadership across the State, Julie is helping make sure that rural communities get the healthcare they need.

So, Julie, thank you for coming all the way out here to testify today.

Over the last few years, we have taken historic steps forward when it comes to making our healthcare system work better for our families. But I believe strongly there is much more we can do to continue to improve affordability, access and quality, and to keep building a healthcare system that works for women, families, and seniors and puts their needs first.

In my home State of Washington where about one out of every five residents lives in a rural area, a critical part of this work is making sure that families can find the doctors they need right in their own communities, regardless of whether they live in Prosser or in Seattle. Of course, this is true in many other parts of the country as well.

This is a serious challenge I have been focused on for a long time. I'm proud that Washington State is doing so much to tackle it head on.

Washington State recently received a Federal grant to explore the role of community paramedics in providing home follow-up care. This approach could reduce emergency room visits and help patients avoid the cost and inconvenience of leaving home to get care.

I also hear repeatedly about the number of new patients getting coverage through the Affordable Care Act across my State. For example, a network of four rural health clinics in Whatcom County reported a 43 percent increase in patients last year. That is great news, but it also means we need to think carefully about how to make sure there are enough doctors and other health care providers to treat all of the patients.

So I'm glad to have the opportunity today to talk about the investments we need to make so we can build on that progress.

The agreement the President recently signed into law to fix the broken SGR system took important steps to support access to healthcare in rural areas. It included funding for health centers and the National Health Service Corps, each of which play a critical role in expanding access to primary care for struggling families, especially in our rural areas.

The SGR legislation also extended funding for teaching health center residencies. My home State of Washington was a leader in setting up these training programs and now primary care providers are being trained in communities with a shortage of healthcare providers from Spokane to Yakima to Toppenish to our Puyallup Tribe. We know that training in rural areas is critical to keeping providers with an interest in rural practice in our high-need communities.

I'm pleased we were able to agree in a bipartisan way to sustain those investments, and I hope we will be able to do even more moving forward.

I'm also pleased that the President's budget maintains investments in other key programs that support rural health. The 340B drug-pricing program, for example, provides outpatient drugs to eligible healthcare providers at lower cost. Twenty-six out of my State's 39 critical access hospitals, which provide crucial support to rural communities, participate in that program.

Similarly, the budget continues to support enhanced payment for rural health clinics and community health centers. In my home

State and many others, these facilities help make sure that when, for example, a parent needs to take a sick child to the doctor or a senior needs follow-up care, it is easier for them to get the treatment they need in their own community. So we really need to make sure they have the resources that they need.

I do also want to express concern that the budget proposes to cut the rural hospital flexibility program. That program helps sustain and improve hospitals in the most difficult to reach communities, including 10 hospitals in my home State. I believe we absolutely need to see continued strong support for this investment in the health and safety of families in rural communities.

Finally, I know rural health access is a priority all of us here care about, so I want to note that the President's budget is able to sustain those investments along with supporting other key priorities from education to infrastructure to defense because it responsibly replaced the harmful cuts from sequestration that are now set to kick back in.

I'm proud that, last Congress, Republicans and Democrats were able to come together to reach an agreement that rolled back sequestration for fiscal years 2014 and 2015. Now with our deal set to expire, I hope we can build on that bipartisan foundation and prevent these harmful cuts to investments in families and jobs and our economy, including critical support for our rural healthcare.

I look forward to working with all of our colleagues on this in the coming weeks and months.

Again, I want to thank all of our witnesses for being here.

Mr. Chairman, again, thank you for holding this really important hearing. This is a topic that means a lot to the people in my State.

Senator BLUNT. Thank you, Senator Murray.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Senator BLUNT. We have two witnesses on the first panel, Sean Cavanaugh, the Deputy Administrator and Director of the Center for Medicare, Centers for Medicare and Medicaid Services; and Tom Morris, the Associate Administrator for the Federal Office of Rural Health Policy, Health Resources and Services Administration. We are pleased you are both here, and we'll listen to your opening statements.

STATEMENT OF TOM MORRIS, ASSOCIATE ADMINISTRATOR, FEDERAL OFFICE OF RURAL HEALTH POLICY, HEALTH RESOURCES AND SERVICES ADMINISTRATION

Mr. MORRIS. Mr. Chairman, members of the committee, I want to thank you for the opportunity to testify today on behalf of the Health Resources and Services Administration (HRSA) and the Federal Office of Rural Health Policy (FORHP) on the topic of rural health.

I'm pleased to discuss not only the challenges that you've already outlined but also some of the accomplishments of our programs. Across the Department of Health and Human Services, there are a range of programs and resources that support rural communities. In 2014, this included $11 billion in grant funding that went to rural communities. FORHP serves as the focal point for rural health activities with a continual focus on improving access to care.

Today, there are nearly 50 million people living in rural areas. That is about 15 percent of the population spread across 80 percent of the land mass in the United States. Individuals in rural communities often have to travel further for their care, and this can have an impact on their health care outcomes.

New research from HRSA shows that, over the past 20 years, life expectancy in rural areas has been consistently lower than urban, and that gap is widening. HRSA helps to improve access to quality healthcare through a variety of initiatives. This includes supporting rural health facilities, investing in community health centers, building a strong healthcare work force, and expanding the use of telehealth.

FORHP has several initiatives that focus on capacity-building in rural communities. We fund the State Offices of Rural Health Grant Program, and that ensures there's a focal point for rural health within each of the 50 States. The Rural Hospital Flexibility Grant Program (Flex Program) and the Small Rural Hospital Improvement Program (SHIP) work with small rural hospitals on quality improvement and stabilizing finances.

HRSA also supports the Rural Health Care Services Outreach Program (Outreach Program), which provides startup funding for pilot projects in rural communities.

Community health centers are obviously an essential component of the rural health care delivery system, because they provide accessible, affordable, and efficient care in underserved communities. HRSA has nearly 1,300 health centers that are supported nationally, with 9,000 health center service sites, and about 50 percent of those service sites serve rural communities.

HRSA recently announced 164 new access point grants for new community health centers. Seventy-four of those are in rural com-

munities, totaling about $45 million in investments that will go to improve access to care in rural communities.

HRSA health professional training programs also work to increase access to healthcare by ensuring that there are providers in underserved areas.

The National Health Service Corps supports loan repayment and scholarships for primary care providers. Almost half of those providers that we support are located in rural communities.

In fiscal year 2014, health profession students supported by HRSA went to 11,000 training sites that are in rural communities. We also invest in community-based rural residency training and work with the 34 Rural Training Tracks (RTTs) around the country.

Telehealth plays an important role in enhancing the healthcare work force and extending its reach. HRSA is currently funding telehealth projects in 230 rural and underserved communities, in 48 different clinical areas. And this includes mental health. We have seen them pilot new initiatives, such as eEmergency care and electronic intensive care unit (eICU) services. We also have 14 telehealth resource centers around the country that provide free technical assistance to communities to either get started in telehealth or to enhance what they are doing in telehealth.

Rural communities have also benefited from the collaborative work of the White House Rural Council, which was created in July 2011. The council is focused on getting Federal agencies and departments to work together to coordinate and serve rural communities better.

I know in our case, this has led to ongoing partnerships between FORHP, the U.S. Department of Agriculture, and the Department of Veterans Affairs on a number of health projects. One example of that is that we have expanded the National Health Service Corps to Critical Access Hospitals (CAHs).

I want to thank you for the opportunity to be here today and to talk about rural health issues. I thank you for your support of HRSA programs. I look forward to answering any questions you might have.

[The statement follows:]

PREPARED STATEMENT OF THOMAS MORRIS

Chairman Blunt, Ranking Member Murray, and members of the subcommittee, thank you for the opportunity to testify today on behalf of the Health Resources and Services Administration (HRSA) and the Federal Office of Rural Health Policy (FORHP) on the topic of rural health programs. I am pleased to discuss not only the challenges and difficulties of rural health delivery but also the accomplishments of our programs.

HRSA is the primary Federal agency charged with improving access to healthcare services for people who are medically underserved because of their economic circumstances, geographic isolation, or serious chronic disease. FORHP serves as a focal point for rural health activities within the Department of Health and Human Services (HHS) and advises the Secretary on the impact of HHS policies and regulations on rural communities.

Across HHS, there are a range of programs and resources that support rural communities. In fiscal year 2014, HHS awarded approximately $11 billion in grant funding to rural communities.[1] FORHP ensures that there is a continual focus on

[1] According to data pulled from the Tracking Accountability in Government Grants System (TAGGS) on February 24, 2015, HHS awarded 7,394 rural awards totaling $11,082,510,598 in fiscal year 2014.

improving access to care, ranging from the recruitment and retention of healthcare professionals to maintaining the economic viability of hospitals and rural health clinics to supporting telehealth and other innovative practices in rural communities.

To begin, I want to thank members of this Subcommittee and your colleagues in the Senate and the House of Representatives for the bipartisan, bicameral efforts you have just undertaken in passing the Medicare Access and CHIP Reauthorization Act of 2015. That legislation extended funding for the Health Centers, National Health Service Corps, and the Maternal, Infant, and Early Childhood Home Visiting programs. The President's Budget for these and other HRSA programs provides important health resources to rural communities.

RURAL HEALTH STATUS

Today, there are nearly 50 million people living in rural areas, representing approximately 15 percent of the population spread across 80 percent of the landmass of the United States. Individuals in rural communities have to travel farther for regular check-ups and emergency services, which can significantly increase the cost of medical treatment and impact outcomes in emergencies when time is critical. Fewer doctors (or other health professionals) and access points, unfortunately, can translate to fewer check-ups, less early detection of disease, and worse outcomes.

New research from HRSA shows that over the past 20 years, life expectancy in rural areas has been consistently lower than in urban areas, and the gap is widening. Mortality from cardiovascular diseases, injuries, lung cancer, diabetes, and chronic obstructive pulmonary disease is much higher in rural areas than in urban areas.

Rural America has traditionally had lower rates of health insurance coverage and higher rates of chronic disease than the population as a whole. Therefore, increased access to insurance and healthcare services is key to improving the health status of rural America. From September 2013 to March 2015, insurance coverage for adults in rural areas has increased 7.2 percentage points from 78.4 percent to 85.6 percent.[2]

HRSA'S SUPPORT FOR RURAL HEALTH

Rural healthcare challenges are fairly well known, ranging from physical access to services to attracting qualified health professionals. Care in rural communities is often delivered through rural health safety net providers such as Critical Access Hospitals, Community Health Centers, and rural health clinics. HRSA helps support this infrastructure to improve access to quality healthcare in rural communities through a variety of programs that include supporting rural health facilities, investing in Community Health Centers, building a strong health workforce, and expanding telehealth usage.

Supporting Rural Health Capacity

As part of its statutory charge, FORHP continually monitors the rural health environment. For example, FORHP's Rural Health Research Centers are analyzing issues such as rural health infrastructure, access to care, and rates of disease and mortality. Since fiscal year 2013, 34 rural hospitals have closed or suspended operations. Our initial review shows there is no single factor driving this issue, and FORHP continues to analyze this issue and the impact on access to care.

The State Office of Rural Health Grant program supports each of the 50 States' rural activities, depending on the needs of their State. State Offices of Rural Health may support quality improvement networks, loan repayment programs for healthcare providers, rural health clinics or emergency medical services. FORHP also provides direct support to facilities through the Rural Hospital Flexibility Grant program and the Small Hospital Improvement Grant program, which work with small rural hospitals and Critical Access Hospitals to support quality improvement and stabilize finances.

HRSA also supports the Rural Health Care Outreach program, which provides start-up funding for pilot grants in rural communities. This includes the Rural Health Outreach Services, Rural Network Development, Small Health Care Provider Quality Improvement, and Delta States Network grant programs. These community-based programs have a new emphasis on performance metrics and program outcomes while building on successful models to expand their services with a focus

[2] Karpman, M., et. al. QuickTake: Substantial Gains in Health Insurance Coverage Occurring for Adults in Both Rural and Urban Areas. Urban Institute: Health Reform Monitoring Survey, April 16, 2015 (http://hrms.urban.org/quicktakes/Substantial-Gains-in-Health-Insurance-Coverage-Occurring-for-Adults-in-Both-Rural-and-Urban-Areas.html).

on sustaining these projects without Federal funding. All of the grantees who completed their pilots in fiscal year 2014 are maintaining their programs without continued HRSA grant support.

HRSA's Maternal and Child Health programs have also improved access to care in rural areas. For instance, the Maternal, Infant, and Early Childhood Home Visiting Program has expanded services to more rural areas. In fiscal year 2014, home visiting services were provided in 321 rural counties or 17 percent of all rural counties in the United States. This is an increase of over 130 percent compared to fiscal year 2010.

Investing in Health Centers

Health Centers are an essential component of the rural healthcare system because they provide an accessible, affordable, and dependable source of primary care for insured and medically underserved patients. HRSA supports nearly 1,300 health centers operating approximately 9,000 health center service sites across the country, and approximately 50 percent of them serve rural communities. This week HRSA awarded 164 New Access Point grants, of which 74, totaling $45.6 million, will create new health center sites in rural communities.

Building a Strong Workforce

A key program focus at HRSA is to increase access for rural Americans to a healthcare provider through its health professional training programs. In fiscal year 2014, HRSA provided rural health exposure to students through 11,389 training sites in rural communities. In addition, HRSA's primary care, oral health, geriatrics, public health and behavioral health training grants supported 180,401 students from rural areas.

The National Health Service Corps supports loan repayment and scholarships for primary care providers, with almost half of the participants serving in rural areas. As of September 30, 2014, 3,529 National Health Service Corps members, or 44 percent of the National Health Service Corps field strength, were working in rural communities and 75 NHSC clinicians were working at Critical Access Hospitals. Half of the nearly 5,000 active NHSC-approved sites are located in rural communities.

HRSA also invests in community-based residency training to improve access to healthcare in rural areas. Rural Training Tracks (RTT) are an innovative model where residents spend 2 of their 3 residency years in a rural community. Over the past 6 years, HRSA has worked to expand the RTT residencies nationally, and the number of training sites has grown from 23 to 34. Our research shows that 70 percent of RTT graduates choose to practice in rural locations after completing the program.

The Affordable Care Act established the Teaching Health Center Graduate Medical Education Program to fund primary care and dental residency programs with a focus on community-based training. This includes a number of rural sites, with over 50 percent of Teaching Health Center grantees training residents in rural communities.

Expanding Telehealth Usage

Telehealth plays an important role in enhancing the reach of the healthcare workforce. HRSA is currently funding telehealth projects that bring specialty care to 231 rural and underserved communities in 48 different clinical areas. This initiative has resulted in innovative applications, such as E-emergency care, as well as advances in home monitoring. Telehealth technology also improves access to and the coordination of mental health services in rural areas, where psychiatrists and psychologists are often scarce. In addition to supporting the development of telehealth networks, HRSA also administers a national network of 14 Telehealth Resource Centers, which provide free technical assistance to communities and providers interested in leveraging this technology including assistance on licensure issues.

INTERAGENCY EFFORTS

Rural communities have also benefited from the collaborative work of the White House Rural Council, which was created in July 2011, and on which I serve as the HHS representative. The Council is focused on enhancing the ability of Federal programs to serve rural communities through collaboration and coordination. For instance, through the work on the Council, HRSA expanded eligibility for the National Health Service Corps Program to Critical Access Hospitals in 2012. This resulted in 229 Critical Access Hospitals being designated as service sites for National Health Service Corps clinicians. The Council also worked with the Centers for Medicare and Medicare Services (CMS) and HRSA to include a number of rural provisions in a Regulatory Burden Reduction regulation that take into account the

unique practice environment for clinicians in rural areas; this regulation was finalized May 2014. Beyond encouraging collaborations among Federal agencies, the Council initiated a public-private partnership with approximately 50 private foundations and trusts that focus on improving rural healthcare.

CONCLUSION

Thank you again for the opportunity to discuss rural health issues with you today and for your support of HRSA's work to improve access in rural communities across the country. I would be pleased to answer any questions you may have.

Senator BLUNT. Mr. Cavanaugh.

STATEMENT OF SEAN CAVANAUGH, DEPUTY ADMINISTRATOR AND DIRECTOR OF THE CENTER FOR MEDICARE, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. CAVANAUGH. Chairman Blunt, Ranking Member Murray, members of the subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to preserve access to quality healthcare for Medicare beneficiaries in rural areas.

Providing high-quality care to the quarter of all Americans who live in rural areas presents unique challenges. Rural areas often have fewer physicians and hospitals, and Medicare beneficiaries in rural areas often reside a significant distance from the nearest healthcare provider.

Medicare beneficiaries often represent a higher percentage of the total patients served by rural providers than urban providers, making these organizations particularly sensitive to changes in Medicare payment policy.

At CMS, we have taken a number of steps to improve services for rural Medicare beneficiaries. First, we have created numerous opportunities for rural stakeholders to engage with CMS to make sure we understand their concerns and challenges. CMS has rural health coordinators at each of our regional offices who meet monthly with central office staff and with representatives from the HRSA Office of Rural Health Policy to discuss emerging issues. CMS also offers regular rural health open-door forums to provide current information on CMS programs, answer questions, and learn about emerging rural health issues.

We are also trying to remove regulatory barriers for rural health providers. Last year, CMS reformed Medicare regulations that we identified as unnecessary, obsolete, or excessively burdensome, which will save providers nearly $3.2 billion over the next 5 years.

This rule included specific provisions targeted at reducing burdens on rural healthcare providers. For example, a key provision reduces the burden on critical access hospitals, rural health clinics, and FQHCs by eliminating the requirement that a physician be held to a prescriptive schedule for being onsite. This provision recognizes telehealth improvements and other developments that allow physicians to provide care at lower costs while maintaining high-quality care.

We are also expanding access to care in rural areas through the use of telehealth and other technologies. Medicare's telehealth benefit allows services that would normally require a patient and their practitioner to be in the same location to be delivered via an interactive telecommunication system. A variety of practitioners are authorized as telehealth practitioners, including physicians, physician

assistants, and nurse practitioners. The statute requires that Medicare pay for professional consultations, office visits, and office psychiatry services.

Each year, CMS solicits public comments on additional services that should be billable under the telehealth benefit through the annual Medicare fee schedule rulemaking process. For 2015, we have added the annual wellness visits, psychoanalysis, family and psychotherapy, and prolonged E&M services.

We are also exploring how we can improve the current telehealth benefit. The Center for Medicare and Medicaid Innovation (Innovation Center) is testing pilot projects that use telemedicine to bring additional services to rural communities. For example, the Health Care Innovation Awards Initiative has awarded a grant to HealthLinkNow, and they are pairing aspects of telemedicine and telepsychiatry with virtual care navigators and behavioral health specialists to serve patients with chronic mental and behavioral health conditions in frontier and rural communities in Wyoming, Montana, and Washington State.

Also this year, we announced the next generation ACO model that is currently accepting applications to begin next year, and that model will be testing expanded use of telehealth services as well.

As you know, critical access hospitals (CAHs) are small rural facilities that serve communities that might otherwise lack access to emergency or basic inpatient care. Medicare reimburses costs at 101 percent of their reasonable cost, rather than the rates set by the applicable prospective payment systems. There are currently more than 1,300 CAHs in the United States.

Here, I would pause and just thank Congress also for extending the Medicare-dependent hospital program, which was in the SGR repeal legislation that you recently passed.

The Rural Health Clinic (RHC) program helps us increase the supply of physicians and nonphysician practitioners serving Medicare patients in rural areas. Approximately 4,000 HRCs nationwide are providing access to primary care services in rural areas.

And finally, the Innovation Center is uniquely positioned to test and evaluate new models to improve access and quality of care for rural communities. For example, the Innovation Center is testing two models that are designed to support ACOs in rural areas. The advanced payment ACO model is meant to help entities such as smaller practices and rural providers with less access to capital and help them get into the Medicare shared savings program.

Similarly, the ACO investment model is a new model of prepaid shared savings that builds upon the experience of the advanced payment model to encourage new ACOs to form in rural and underserved areas.

CMS recognizes the challenges faced by beneficiaries and providers in rural areas. I look forward to continuing to work with HRSA and with Congress on further improvements to deliver quality care to Medicare beneficiaries, regardless of their location.

Thank you again, and I'm happy to answer your questions.

[The statement follows:]

PREPARED STATEMENT OF SEAN CAVANAUGH

Chairman Blunt, Ranking Member Murray, and members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to preserve access to quality healthcare for Medicare beneficiaries in rural areas. Effectively providing healthcare to the quarter of all Americans who live in rural areas presents unique challenges. Medicare beneficiaries in rural areas often reside a significant distance from the nearest healthcare providers and in medically underserved areas. Medicare beneficiaries often represent a higher percentage of the total patients served by rural providers than urban providers, making these businesses particularly sensitive to changes in Medicare payment policy. Rural areas often have fewer physician practices and hospitals, and face longer travel times to specialists. Due to higher rates of uninsured, rural providers rely disproportionately on Medicare payments.

CMS has a number of efforts to improve access to services for rural Medicare beneficiaries. CMS has rural health coordinators at each of our Regional Offices, who meet monthly with participation from CMS central office staff and the Health Resources and Services Administration (HRSA) to discuss emerging issues. Through the Rural Health Open Door Forum, CMS engages with stakeholders to provide current information on CMS programs, answer questions, and learn about emerging rural health issues. Through Medicare's teleheath benefit, Rural Health Clinics, and Critical Access Hospitals, CMS is making sure that rural beneficiaries have access to physician and hospital services that may not otherwise be available in their communities. Moving forward, the Center for Medicare and Medicaid Innovation is testing new payment and delivery models such as Accountable Care Organizations (ACOs) with a focus on how to explore and support efforts to make further strides in improving the quality of care in rural areas.

WORKING WITH STAKEHOLDERS TO MINIMIZE BURDEN

Last year, CMS finalized a rule that included reforms to Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and other healthcare providers, which will save nearly $660 million annually, and $3.2 billion over 5 years. This rule specifically outlined ways to reduce burdens on rural healthcare providers. For example, a key provision reduces the burden on very small Critical Access Hospitals, as well as Rural Health Clinics and federally Qualified Health Centers, by eliminating the requirement that a physician be held to a prescriptive schedule for being onsite. This provision seeks to address the geographic barriers and remoteness of many rural facilities, and recognizes telehealth improvements and expansions that allow physicians to provide many types of care at lower costs, while maintaining high-quality care.

The Rural Health Open Door Forum (ODF) provides an opportunity for stakeholder input on any issue that affects healthcare in rural settings. We cover topics such as Rural Health Clinic, Critical Access Hospital, and federally Qualified Health Center issues, among others. For example, CMS recently had a call devoted exclusively to Veterans Affairs issues and had an expert from VA to assist rural providers with billing for services provided to veterans. Topics that frequently arise in this forum often deal with payment policies, claims processing and billing for services, cost report clarifications, classifications for & qualifications of rural provider types, and the many special provisions of law designed specifically to improve rural healthcare. Timely announcements and clarifications regarding important rulemaking, quality program initiatives, and other related areas are also included in the Forums.

PROMOTING ACCESS TO CARE IN RURAL AMERICA

CMS administers a number of programs that seek to expand access to services in rural areas. Medicare's telehealth benefit allows beneficiaries to receive certain services from physicians located outside their community. Rural Health Clinics, help to provide access to primary care services in rural areas while Critical Access Hospitals provide access to inpatient and outpatient hospital care where care would otherwise be unavailable.

Expanding Telehealth Access for Rural Areas

Advances in telecommunications technology have improved access to rural healthcare for such services as radiology and remote monitoring without the need for special provisions of regulation or statute. These technologies allow the transmission over great distances where the practitioner and the patient are remotely located. Medicare's telehealth provisions also allow services that would normally require the patient and their practitioner to be in the same location to be delivered

via an interactive telecommunications system. Telehealth can help to expand access to specialized services that may not otherwise be available at facilities in some rural areas. Medicare payment for telehealth services is prescribed in section 1834(m) of the Social Security Act. According to the statute, Medicare pays for telehealth services that are furnished via a telecommunications system, by a physician or practitioner, to an eligible telehealth individual, where the physician or practitioner providing the service is not at the same location as the beneficiary. The telecommunications system generally must include, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient at the originating site and the physician or practitioner at the distant site.

Beneficiaries eligible for telehealth services are those enrolled in Medicare Part B who receive such services at an originating site identified by statute, which includes the office of a physician or practitioner, a hospital, a rural health clinic, and a skilled nursing facility. An originating site must be located in a Rural Health Professional Shortage Area or in a county that is not designated as part of a Metropolitan Statistical Area. Entities participating in a Federal Telehealth Demonstration as of December 31, 2000 also qualify as originating sites.

A variety of practitioners are authorized as telehealth practitioners, including physicians, physician assistants, and nurse practitioners. Payment for the physician or practitioner furnishing telehealth services is made under the Medicare Physician Fee Schedule. The statute requires that this payment be equal to the payment for a face-to-face service. The originating site, where the beneficiary receives telehealth services, is paid a facility fee under Medicare Part B.

Currently, 75 codes are covered as telehealth services under Medicare. The statute specifically requires that Medicare pay for professional consultations, office visits, and office psychiatry services. The statute permits the Secretary to pay for other telehealth services which are considered through the annual physician fee schedule rulemaking process.

As we have established in rulemaking, services can be added if they are either:

—Similar to existing telehealth services, or

—Dissimilar to existing telehealth services and will produce demonstrated clinical benefits to a patient if delivered by a telecommunications system.

For 2015, CMS added psychoanalysis, family psychotherapy, annual wellness visits, and prolonged evaluation and management services as telehealth services.

In addition to Medicare payment for telehealth services as prescribed by statute, telehealth is a component of various initiatives currently being tested by the Centers for Medicare and Medicaid Innovation. For example, under the Health Care Innovation Awards initiative HealthLinkNow, Inc. is pairing aspects of telemedicine and telephyschiatry, with virtual care navigators and behavioral health specialists, to serve patients with a variety of chronic mental and behavioral health conditions in frontier and rural communities in Wyoming, Montana and Washington State. Also, organizations participating in the Bundled Payments for Care Improvement Initiative are eligible to waive some of the geographic restrictions so that they can bill for telemedicine services and receive Medicare fee-for-service payments. The Innovation Center's work may help us better understand the potential value of telehealth for improving the quality of care and reducing expenditures.

Critical Access Hospitals

Critical Access Hospitals (CAHs) are small rural facilities that serve communities that might otherwise lack access to emergency or basic inpatient care. Medicare reimburses CAHs at 101 percent of their reasonable inpatient and outpatients costs, rather than at the rates set by the applicable prospective payment systems or fee schedules. There are currently more than 1,300 CAHs in the United States. In order to be designated as a CAH, a Medicare-participating hospital must meet the following criteria:

—Be located in a State that has established a State Medicare Rural Hospital Flexibility Program;

—Be designated by the State as a CAH;

—Be located in a rural area or an area that is treated as rural;

—Be located either more than a 35-mile drive from any other CAH or hospital, or more than a 15 mile drive in areas with mountainous terrain or only secondary roads; OR prior to January 1, 2006, were certified by CMS as a CAH based on State designation as a "necessary provider" of healthcare services to residents in the area.

—Maintain no more than 25 inpatient beds that can be used for either inpatient or swing-bed services;

—Maintain an annual average length of stay of 96 hours or less per patient for acute inpatient care (excluding swing-bed services and beds that are within distinct part units); and

—Furnish 24-hour emergency care services 7 days a week.

Since their creation, CAHs have provided needed hospital services to millions of Medicare beneficiaries. CMS is committed to preserving the CAH program and believes in ensuring that CAHs provide quality care to isolated communities without another nearby source of acute inpatient and emergency care.

When the program was created, States were permitted to designate hospitals as "necessary provider" (NP) CAHs. Designation as a NP CAH exempted the hospital from the CAH distance requirement, although these CAHs are still required to comply with all other CAH Conditions of Participation, including the rural requirement. Although Congress eliminated the ability to designate new NP CAHs after January 1, 2006, all existing NP CAHs remain permanently exempt from the distance requirement. Currently, about 75 percent of all CAHs are designated as necessary providers.

In 2013, the HHS Office of Inspector General (OIG) found that 64 percent of CAHs would not meet the distance requirements, including a number that are grandfathered and currently exempted from the distance requirement and recommended that CMS seek legislative authority to remove the distance requirement exemption, thus allowing CMS to reassess these CAHs.[1] OIG conducted an analysis of the services provided by nearby hospitals and found that approximately 93 percent of hospitals located near CAHs that would be affected provided emergency services.

The President's fiscal year 2016 Budget proposes a more limited change than OIG called for that would prevent CAHs, including those currently designated as necessary providers, which are within 10 miles of another CAH or hospital from maintaining certification as a CAH. This change is necessary to ensure that only facilities whose communities depend upon them for emergency and basic inpatient care will be certified as CAHs and receive reasonable cost-based reimbursement. Under this proposed change, CAHs that are within ten miles of another CAH or hospital would be provided the opportunity to convert to certified hospital status, and would then continue to receive Medicare reimbursement through the ordinary inpatient and outpatient prospective payment systems, under which the majority of acute care hospitals are paid.

As requested by this Committee, CMS conducted an analysis on the impact of this proposal on access to services in rural communities.[2] Our analysis estimated that a maximum of 47 CAHs, out of a total of 1,339 certified CAHs, might be affected by this proposal. Moreover, facilities losing their CAH designation would not necessarily close. Instead, it is anticipated that many of these CAHs would continue to participate in Medicare as hospitals paid under the applicable prospective payment system, and would continue to provide hospital services to their communities without reliance on CAH designation. Hospitals that transitioned from their CAH status would be eligible for the Hospital Value-based Purchasing Program, which provides financial incentives for high quality of care and improvement in quality.

In the event that some of the potentially affected CAHs were to close, CMS analysis found that there likely is sufficient capacity in nearby facilities to provide the services any closed CAH had previously provided. CMS conducted an analysis of recent Medicare and cost report data for the potentially affected CAHs, as well as for the hospitals located within 10 miles of these CAHs. Overall, the data suggests that there would be no significant issues related to access to inpatient acute care services or skilled nursing services for the communities currently being served by the potentially affected CAHs should the CAH cease to provide services rather than convert its Medicare agreement to participate as a hospital.

The President's fiscal year 2016 Budget also proposes changing reimbursement of CAHs to pay them for their actual costs of providing care. This change would generate savings to the Medicare program while protecting access to care by reimbursing hospitals for 100 percent of their costs.

Rural Health Clinics

The Rural Health Clinic (RHC) program was created to address an inadequate supply of physicians serving Medicare patients in rural areas and to increase the

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[1] Department of Health and Human Services Office of Inspector General, Most Critical Access Hospitals Would Not Meet the Location Requirements if Required to Re-enroll in Medicare, August 2013, OEI–05–12–00080.

[2] Centers for Medicare and Medicare Services, Report on Critical Access Hospitals, March 26, 2015.

use of non-physician practitioners such as nurse practitioners and physician assistants in rural areas. Approximately 4,000 RHCs nationwide provide access to primary care services in rural areas. Through this program, CMS provides advantageous reimbursement as a strategy to increase rural Medicare and Medicaid patients' access to primary care services. An RHC is a clinic that is certified by CMS to receive special Medicare and Medicaid reimbursement. RHCs are required to employ a nurse practitioner (NP), or a physician assistant (PA), and a NP, PA, or certified nurse midwife must be on-site to see patients at least 50 percent of the time the clinic is open, subject to State and Federal supervision requirements. RHCs provide outpatient primary care services and basic laboratory services. RHCs must be located within non-urbanized areas that have healthcare shortage designations.

RURAL HEALTH EFFORTS AT THE CENTER FOR MEDICARE AND MEDICAID INNOVATION

Congress created the CMS Innovation Center for the purpose of testing innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits. The Innovation Center is uniquely positioned to test and evaluate efforts to identify and address challenges to access and quality of care for rural communities. In addition to these efforts to test improvements to telehealth, the Innovation Center is testing two models designed to support Accountable Care Organizations (ACOs) in rural areas. The Advance Payment ACO Model is meant to help entities such as smaller practices and rural providers with less access to capital participate in the Medicare Shared Savings Program. The ACO Investment Model is a new model of pre-paid shared savings that builds on the experience with the Advance Payment Model to encourage new ACOs to form in rural and underserved areas.

Several projects focused on rural areas are also being tested through the Innovation Center's Health Care Innovation Awards initiative:

—The University of Kansas Hospital Authority is testing a model to implement the Rural Clinically Integrated Network (RCIN) to improve heart health and stroke survival for rural Kansas.

—Catholic Health Initiatives Iowa Corporation received an award to test a model to transition a network of rural critical access hospitals in Iowa to value-based care through improved chronic disease management, increased clinical-community integration and 'lean' process improvement initiatives.

—Northland Healthcare Alliance is implementing a modified version of the Program of All-Inclusive Care for the Elderly (PACE) model in rural North Dakota.

—St. Luke's Regional Medical Center is testing remote intensive care unit (ICU) monitoring and care management in rural areas of Idaho and Oregon.

In addition, the Innovation Center is implementing the Congressionally-mandated Frontier Community Health Integration Project (FCHIP) demonstration, focused on supporting essential health services in sparsely populated rural counties served by CAHs.

CONCLUSION

CMS recognizes the challenges faced by beneficiaries and providers in rural areas. We are helping to address provider shortages through the Critical Access Hospital and Rural Health Clinic programs, and expanding the use of telehealth. We continue to test new delivery models to improve rural healthcare through the Innovation Center. I look forward to continuing to work with HRSA and the Congress on further improvements to deliver quality healthcare to Medicare beneficiaries, regardless of their location.

FISCAL YEAR 2016 PRESIDENT'S BUDGET

Senator BLUNT. Thank you both. Let me ask you a couple questions, and we will do 5-minute rounds here.

Mr. Morris, the budget the administration submitted would have cut your budget by $20 million. Did you ask for that cut?

Mr. MORRIS. Mr. Chairman, we support the President's budget and the request that came forward. We think that it supports the key programs for our office. It includes continued funding for the outreach program, for the Rural Hospital Flexibility Grant Program, for our policy and research activities. We think that those are the programs that can be most effective in meeting needs.

Senator BLUNT. So where are going to spend $20 million less than you are spending this year?

Mr. MORRIS. The President's budget, there is that decrease, yes, sir.

Senator BLUNT. What programs are you going to decrease?

Mr. MORRIS. There is no request for the funding of SHIP, and there is no request for the funding of the Rural Access to Emergency Devices (RAED) program. In the case of these programs in the administration's request, these are challenging budget times, and they require some tough choices sometimes. So I think the President's budget reflects a request for the programs that we think are really effective in meeting the need.

In the case of SHIP, we have the Flex Program and there's a $25 million request for that. That program focuses on what we see as the most vulnerable of the rural hospital sector, which are the CAHs. So there will be $25 million requested to support quality improvement and performance improvement, working through the Flex Programs and partnering with the States in those activities.

In the case of the RAED Program, this is a program that places automatic external defibrillators in rural communities. We think that the need has largely been met in that program, not only through Federal funding but also through State and private sector funding. But we do allow people to come in through our Outreach Program funding to get at the same issue. So an applicant could come in for Outreach Program funding or network funding under the program that is requested in the budget and do the same thing as the RAED program in the sense that they could develop a program that seeks to purchase those defibrillators and put them in rural communities.

So for the remaining need that is out there, we feel it can be met through the Outreach Program.

Senator BLUNT. And the hospital improvement program that you would continue is a $25 million program?

Mr. MORRIS. Yes, sir.

Senator BLUNT. Is that in the current year that you are spending $25 million and proposing to spend another $25 million next year?

Mr. MORRIS. Correct.

Senator BLUNT. And then the $20 million that you would have this year for similar purposes would go away in the President's budget?

Mr. MORRIS. Yes, sir. The SHIP program, the Small Hospital Improvement Program, there's no request for that. It had been funded historically at $15 million. And the other $5 million is from the request for the Rural Access to Emergency Devices Program.

TELEHEALTH

Senator BLUNT. What obstacles do you see in telehealth? We have people telling us that there are still issues that they are trying to work through with your department in telehealth. What would you say would be the top obstacles to move forward on telehealth?

Mr. MORRIS. One of the issues we're trying to get at for telehealth is the whole issue of cross-state licensure, and the fact you may have providers who are located in one State but providing

telehealth services in another State. So Congress has provided funding through our Telehealth program for the Licensure and Portability Grant program.

We currently have grants with the Federation of State Medical Boards and also with the State and provincial psychology boards. What we are trying to do with those grants is work with licensing boards so that if, say, a psychologist was practicing in Missouri but was providing services in another State, rather than having to complete two completely different licensure grant applications, they could adopt a common licensure so it makes it easier for somebody to practice across those State lines, but it still protects patient safety, in terms of the licensing and credentialing for that provider. So that is one way we're trying to get at it.

The other thing I think that we found, we have been investing in telehealth for a number of years and we know it improves access to care. One of the challenges is finding out which applications have the best clinical outcomes. So the evidence-base for telehealth could be expanded, so one of the things we did this past year was put money into an Evidence-Based Network Grant Tele-Emergency program. What we are trying to understand is how does that outcome from using tele-emergency care compare to when you have those services face-to-face.

I think that is a question any insurer would want to know. The more we can learn about the evidence base and what works best in telehealth I think can then help us target investments moving forward.

Senator BLUNT. Maybe we can move forward on that a little bit, even with the next panel and our telehealth witness there.

Senator Murray.

HEALTH WORKFORCE

Senator MURRAY. Mr. Morris, I'm a strong supporter of HRSA's health care work force training programs. In particular, the National Health Service Corps provides critical support to physicians and other providers that agree to work in our rural and underserved areas.

I also just want to recognize your agency's important role in documenting work force shortages through the National Center for Health Work Force Analysis.

I wanted to ask you, what do the current projections say about our national healthcare work force shortage?

Mr. MORRIS. Sure. Demand is expected to increase for primary care services through 2020. This is due to the fact that the population is aging, the population is growing, and then there are also impacts that you referenced earlier in terms of more folks having coverage may result in them seeking more services.

So the national center has done some projection work, and what they are projecting is that there will be a shortage of approximately 20,000 full-time equivalent physicians by 2020. Now this is mitigated somewhat if we are able to really take advantage of the supply of nurse practitioners (NPs) and physicians assistants (PAs) and use them to the full extent of their training. So if that really happened and if the trends in NP training and deployment con-

tinue, and the same thing for PAs, if that happens, I think the shortage drops down to about 6,000.

Senator MURRAY. So what kind of healthcare providers are most needed in our rural communities?

Mr. MORRIS. I think the full spectrum of providers, primary care and that includes both the physician and nonphysician providers. But we see shortages in mental health, and that is for everything from licensed clinical social workers to psychologists. Psychiatry is not a service you often find in rural communities. But even some rural communities have challenges in terms of the allied health work force and regular nursing.

So those are all challenges I think that rural communities face.

Senator MURRAY. Talk to me about how the additional resources that you requested for the National Health Service Corps in the budget help address shortages like we have in rural Washington.

Mr. MORRIS. The administration's request would dramatically increase the funding for the National Health Service Corps. The advantage is that right now we fund National Service Corps Loan Repayment Scholarships down to the level of funding that is available based on how underserved they are, basically what their score is in a Health Professional Shortage Area (HPSA).

So the more funding that is available, as in the President's budget, will allow us to fund more clinicians to be supported in those communities. So that would mean a lower HPSA score, which would mean more rural communities would have access to it.

It has been a lifeline for rural communities. As I noted before, just under 50 percent of the placements for the National Health Service Corps go to rural communities, while rural only represents about 17 percent of the population.

TEACHING HEALTH CENTERS

Senator MURRAY. How can we continue to leverage the Teaching Health Centers program to make sure that residents stay in rural areas? Is there anything we can learn from this program to attract other specialists? Talk to me about that.

Mr. MORRIS. Well, one of the big lessons from the Teaching Health Centers program is that you can do residency training in a community-based setting. So much of our traditional residency training takes place in large academic health centers, and if we can get more folks exposed to community-based training, the hope is that they will be interested in that community-based training, so we will see them working in our rural health clinics and our community health centers and our small hospitals.

So I think the Teaching Health Centers shows a path forward, and that informed the President's request around really reshaping how we train physicians and creating a new grant program to do community-based training, and that would include rural communities.

We know also from some of the work we do at the RTTs, which started in your State in Colville, Washington. This is a unique model where they do 1 year in an academic health center and then 2 years in a rural setting, and 70 percent of the graduates of those are RTTs end up practicing in rural communities.

So I think the evidence is pretty strong, that if we do more community-based training, we will meet those needs better. The Teaching Health Centers are the first step, and I think the President's request is another step toward that.

Senator MURRAY. I completely agree. I've seen this working in my State. Where you practice and do your residency really makes a difference on where you stay. When we have such a need in our rural communities, having those residents in those rural communities during their residency, it works really well. So I hope we can continue to build on that. Thank you.

Senator BLUNT. Senator Cochran.

TELEHEALTH

Senator COCHRAN. Mr. Chairman, thank you for convening this hearing on the challenges that we are facing in our rural communities throughout America in making available health care services, some of which are partially paid for by Federal Government agencies. We hope to learn from this hearing ways to provide the needed resources, up to the point where we are authorized to do so.

It has been brought to my attention that the Health Resources and Services Administration has released a grant notice regarding the intent to provide funding for a telehealth-focused research center cooperative agreement.

Could you tell us more about what that is? What are you looking for in an applicant? What are the goals that would be funded by this cooperative agreement?

Mr. MORRIS. I think this builds on the comment I made earlier that, again, we know telehealth improves access. I think the real challenge is finding out what the impact of that increased access is. So what we are hoping to do with this research center is to help build the evidence base for finding out which applications work best and deliver the best outcomes.

So what we are looking for are experienced researchers who can do comparative outcome research, so we can look at you provide a telehealth service and here's the outcome. How does that compare to whether you had it face-to-face?

I think that will really inform the evidence base.

Senator COCHRAN. Are you encouraged by the results of your applications and those who are petitioning the government to choose them?

Mr. MORRIS. We have gotten a lot of calls on this funding opportunity just in the week it has been out there.

Senator COCHRAN. Mr. Cavanaugh, I understand the Centers for Medicaid and Medicare Services restrict reimbursement for telehealth based on geographic locations.

How do you administer that? How do you choose which urban areas, for example, are more eligible than others for telehealth reimbursement?

Mr. CAVANAUGH. Thank you for the question, Senator.

In the statute, it gives us instruction to allow telehealth to be provided in certain geographic areas. I'm pleased that, with help from our colleagues at the Office of Rural Health Policy, a few years ago we changed our regs to expand the definition of rural

areas that qualify. But, the geographic restrictions really originate in the statute.

The good news is, through the Innovation Center, which Congress created, we are able to move beyond those barriers and test new models of telehealth without regard to the geographic barriers and some of the other statutory restrictions. We have a number of very interesting telehealth models that are being tested currently, including the health link model that I mentioned in my testimony.

Senator COCHRAN. Thank you very much.

Senator BLUNT. Senator Moran.

RURAL HOSPITAL CLOSURES

Senator MORAN. Mr. Chairman, thank you very much. Thank you for you and Senator Murray having this hearing, a very important one, certainly for a Senator from Kansas, but really for the country.

Let me start with Mr. Morris. Tell me, what statistics are there that demonstrate, over a period of time, how many rural hospitals are closing or in addition to that are threatened to close?

I've seen an AP story just in the last few days indicating that 50 rural hospitals have closed, a total 50 hospitals in the rural U.S. have closed since 2010, and the pace has been accelerating with more closures in the past 2 years than in the previous 10. This is according to National Rural Health Association.

I have also seen the study from the North Carolina research organization indicating 47, I think is the number of hospitals that have closed.

My question is, do you consider those numbers accurate? And what kind of study or analysis, do you have about cause? What can we pinpoint the cause for those closures? And what is your expectation for that trend in the future?

Mr. MORRIS. Senator Moran, thank you for that question.

This is an issue we have been tracking, and those numbers align with what we found. We are working with the North Carolina Rural Health Research program. They are one of our rural health research centers, and their work is very solid.

We are trying to get a better handle on what is driving the closures. There is not one single factor behind it. I think it is a very community-specific sort of issue.

In some cases, it may be that the community has lost population and may not have the volume to support a full-service hospital. But there are also a variety of other market pressures that may be having an impact on it.

It is, certainly, something we are going to continue to study further, and the North Carolina Rural Health Research program will probably lead those efforts. We will be happy to share with you all of those findings.

They are looking at a study that we hope to have out next year that looks at what happens in a community after a hospital closes.

Just doing some informal calling around to get a handle on this, in some communities, hospitals close and we have seen a situation where another provider can step in and still provide a broad range of ancillary services. Maybe they expanded their telehealth. Maybe

they expanded the clinic hours, so they're not just open 9 to 5, and the community seems largely okay with how it played out.

In other cases, there is a definite gap when a hospital closes, specifically around emergency department services.

But with the 34 hospitals that closed since 2013, that is an uptick from the previous 2 years. What is interesting is the same number of hospitals have closed in urban areas, but I think, as you know, when a hospital closes in a rural area, it is a little different than when it closes in an urban area.

So this is going to be a real priority for us from a research perspective over the next couple years. We will certainly work with our colleagues at CMS and across the department to better understand it and see what other resources can be brought to bear.

Senator MORAN. Mr. Morris, I would be interested in knowing the research outcome of what happens to a community following a hospital closure, but I also would encourage for research to be conducted that would indicate what steps could have been taken to have prevented the closure in the first place. I'm pretty certain that in most instances the research will demonstrate significant consequences related to hospital closures, often pretty dire, to a community and to patients. I think we ought to be more prospective as how we avoid this, what are the precipitating causes.

I agree with you. It is not one thing. Population and demographics is something maybe we can't control here. But, certainly, the regulatory environment, the cost structure, is important to those hospitals, physician and other healthcare provider recruitment, retention, and then the reimbursement rate.

HOSPITAL REIMBURSEMENT

And on that topic, I wanted to ask you about the idea of cost-based reimbursement. What is the evidence that when we say we are reimbursing costs at 101 percent of cost that that has any real meaning in the real world? Isn't the reality that when we say we are reimbursing more than cost, not all costs are reimbursable, so we create this misperception that a critical access hospital is getting something more than what it actually costs them to operate.

Is there an analysis? Can you quantify really what is going on in hospital when we tell them, or when we tell the public that your hospital is getting 101 percent of costs when it really is reimbursable costs?

Mr. MORRIS. As you know, that is a very complicated question. It goes back to historical costs of the hospital, and if they converted to critical access, what those historical costs feed into, what they would be paid under this CAH reimbursement status.

So it does vary from State to State. But I would be happy to get back with you and also with your staff. We can connect you with some of the folks at the University of North Carolina as well as some of our experts to better understand it.

Senator MORAN. I would welcome that, but in today's setting, can you confirm for the record that when we talk about reimbursing a hospital its costs, that it is receiving something significantly less than actual cost of operating a hospital?

Mr. MORRIS. I think in some cases, that may be true. It's hard to say that nationally, because it's different, depending on the his-

torical cost structure of the hospital. It might be different for Kansas than it is for Alabama.

As you know, how hospitals structure their cost is a science unto itself. So I'm happy to get back to you on more of that.

To respond to your earlier question, we are trying to do what we can to avoid closures. I think what we have done with investments in the flex program, we are really focusing on making sure that hospitals—CAHs are not required to report quality data to Medicare, but we encourage them to do that. So we've seen a significant increase in the number of CAHs reporting their quality, because if they can do that, if they can benchmark their quality, they can demonstrate more value back to their community.

We also awarded a contract last year to work with rural hospitals that are struggling in high poverty counties. So we have an example in Tallahatchie, Mississippi, Mr. Cochran's State, where we were able to send consultants in there to help them turn around their finances and improve their financial bottom line. So with the resources we have, we are keenly aware of the precarious nature of some rural hospitals. And whether it is our Flex Program, or that contract, or even our outreach and network funding, we can begin to get at that.

So we do want to do all we can to help stabilize folks so that we're not in a closure situation.

Senator MORAN. I would tell you that very few critical access hospitals in Kansas who receive "cost-based reimbursement" are able to survive in the absence of a tax levy to support the hospital.

Mr. MORRIS. Yes, sir.

Senator MORAN. Thank you, Mr. Chairman.

Senator BLUNT. Thank you, Senator Moran.

Senator Capito.

Senator CAPITO. Thank you, Mr. Chairman.

I want to thank the panel. I am from the State of West Virginia, so I would like to ask a question to Mr. Cavanaugh. In your testimony, you talked about the new initiative HealthLinkNow, which is pairing telemedicine and telepsychiatry. This program is currently being tried in three States, and I was wondering what measurable data the pilot program is showing you, and what are the prospects of expanding this to other rural communities? As we know, there is a shortage of mental health professionals everywhere and rural America is probably exponentially so.

Mr. CAVANAUGH. You are correct, Senator. Before I was at the Center for Medicare, I was at the Center for Medicare and Medicaid Innovation. When we did the innovation awards, there were quite a few telehealth and telemedicine proposals, and I was surprised at the number that had a link to behavioral health and psychiatry, just as you mentioned.

We have some early evaluations of those, but they are very qualitative, meaning case studies of how they've fared in standing up the program. We hope in the next year to have some quantitative data.

I will remind the committee, the statute set up the Innovation Center and said these models can be tested and they can be expanded if they meet certain cost savings and/or quality improve-

ment standards. So, we intensively evaluate all of these models. So, we hope in the next year to have some more quantitative results.

One of the things that I would say is many of the Innovation Center models are being tested at very large scale. Some of them are being tested at smaller scale, and this would be one that is at smaller scale. So, I think, even if we get very promising data, I don't think the next step would be to go national with it. It would probably be to incrementally move to more communities.

So, we are hopeful to have data soon. We've made all of our evaluations public. And we will, certainly, share it with this committee as soon as we have news.

Senator CAPITO. Well thank you. One of the obstacles that I think all of us who live in rural States are combating every day is the lack of high-speed rural broadband access. And certainly, that has to be impacting telehealth into the rural health initiatives.

Are you running into this in some of your telemedicine initiatives? Is this a problem that you have identified as well? Or do you have anything on that?

Mr. CAVANAUGH. Certainly, anecdotally, we talked to some of our awardees. It does affect what communities they think they can test these models in and what communities they wish they could test these models in.

We don't feel like we, at Medicare, have the tools to help with that. But, we do recognize it as a barrier, and it is important because I do think, whether it is telehealth or other technology, telemedicine technologies, I do think broadband is going to be essential to that.

RURAL TRAINING TRACKS

Senator CAPITO. And it's a challenge.

Anecdotally recently, Mr. Morris, in talking with our hospitals and emergency room physicians, we were talking with an anesthesiologist the other day, one of the things that is cropping up now is the lack of total number of residencies so that there are several hundred. I've heard 500, and then may be into a thousand graduates of medical schools who don't match and they don't get a residency. That obviously stalls out their professional career. They've got student loans and all sorts of other issues.

I think we should be looking at rural health as a way to expand the availability of residencies to fill this gap. I know you talked a little bit about residencies in your opening statement.

Mr. MORRIS. We do recognize the challenge you've just laid out, and one of the things we initiated about 5 years ago was to put a grant together with the National Rural Health Association to expand these RTTs. There were about 23 of these across the country, and that number had been fairly static over the years, and now there are about 34.

So we have increased the number of RTTs. And what is unique about the RTTs is that although there is a cap on the total number of Medicare residencies that can be supported, there is flexibility under that cap for new RTTs. So there is an opportunity to create rural residencies and to work with our partners at CMS through that flexibility under the residency cap.

And again, we know this is an evidence-based model. It works. And we have seen some real success from it.

Senator CAPITO. Well, I, certainly, would be very supportive of any kind of way—this could help solve more than just one problem here, if we were able to expand that and use it wisely.

And I'll just make comment at the end. I think those of us who live in rural America are always frustrated that it is assumed by the more urban areas that it is cheaper to deliver medical services in a rural area because typically wages are maybe a little bit lower. But you have workforce shortages. You have travel time. You have all kinds of other issues that it's frustrating for us, I think, to make the case. I mean, we are always having to make the case, as you know. You are in this, too.

So I applaud your efforts in helping us deliver the message. All of the health care dollars need to be—it is not as easy in rural America as some in the urban areas might think it is. Thank you.

Senator BLUNT. Dr. Cassidy.

Senator CASSIDY. Hey, gentlemen. I was looking down but listening. So one of you pointed out the cause for closures is multifactorial. I accept that. But I'm curious.

It seems like the only business model that is going to actually work in a rural setting is volume, because you don't have the critical mass of capitated patients, even if you did, partly because so many are uninsured or partly because your payer makes Medicaid, for example, is so poor.

So I say this because we just passed an SGR bill, which promoted alternative payment models. The Accountable Care Organizations all rely upon value-based purchasing, with the implication that volume decreases.

So is one of the factors in this multifactorial problem that the business model can only survive with certain volumes and the big push now is away from volume and more toward quality? Have you run models on that? Do you have studies regarding this? Because I'm wondering if there is any hope for these hospitals besides an outright subsidy, be it through the tax base or be it through some Federal legislation.

Mr. CAVANAUGH. I think, Senator, you're putting your finger on a very important challenge that we all face as we move forward, which is, as you say, how do rural health providers not just survive but thrive into the new setup of the SGR reform bill.

I think there are multiple ways this can happen. One is——

Senator CASSIDY. Let me ask, before you go forward, because I have a specific question. Do you have studies showing the effect of, say, an Accountable Care Organization, which needs a critical mass of people with a very good payer mix on a capitated basis receiving their preponderance of care at this institution? Is there such a study looking at whether or not this model will work for rural hospitals?

Mr. CAVANAUGH. So, I am not aware of any studies. We are pleased to say, though—there has been a lot of skepticism whether ACOs can work in rural areas. In the shared savings program, which I'm responsible for, we have about 7.3 million Medicare fee-for-service beneficiaries aligned with ACOs, and about 15 percent of those beneficiaries are living in rural America.

Senator CASSIDY. Let me ask, though, because you can live in rural America, but still get your health care at Geisinger. So it wouldn't be that you had a local hospital. It could be that you are linked with an urban hospital or semi-urban or something such as that.

So are these in the rural hospitals? What is the health of rural hospitals in those settings in which you just described, the ACOs you just described?

Mr. CAVANAUGH. So, you make a good point. I would remind you, though, that the beneficiaries are aligned with an ACO through their use of primary care, not necessarily where they get their inpatient care.

Senator CASSIDY. I thought it was the preponderance of care.

Mr. CAVANAUGH. Preponderance of primary care, though.

Senator CASSIDY. Okay.

Mr. CAVANAUGH. But, you make a good point, which is you could live in a rural area and be an ACO that has a significant urban presence, because there are ACOs that span both types of communities, and there are those that are strictly in rural areas.

There's one ACO called a national rural ACO, which is combining rural communities across the country.

I think it is early for us to know the relative success of rural versus urban ACOs. We really only have about 2 years——

Senator CASSIDY. I'm sorry. I have limited time, so I'm trying to focus.

What is the health of the rural hospitals in those areas in which there is an ACO which has responsibility, if you will, for the rural patient?

This is about hospitals. So if we have ACO which kind of aggregates the care into an urban hospital setting, that would actually be starving the rural hospital.

Mr. CAVANAUGH. I don't have the data that you are requesting. We can, certainly, go back and see if it is something we could compile for you.

Senator CASSIDY. Okay.

Continue then, because that was kind of the point. You had another point. I'm sorry I interrupted, so continue.

Mr. CAVANAUGH. I just wanted to make the broader point, Senator, that we have heard from a lot of rural providers that they are excited about the prospects of getting into new payment models, because they do find fee-for-service payments frustrating. They think they are efficient providers, and in many cases probably are.

We do have one large initiative out of the Innovation Center called transforming clinical practice, and this is where we are going to help small practices, not the hospitals necessarily, but small physician practices, give them technical assistance so they can develop the infrastructure and the knowledge——

Senator CASSIDY. In that, I will just go back to this, because the hub is what matters here. If the hub is a rural hospital, that could potentially help, although under value-based purchasing, you are still going to be emphasizing keeping people out of the hospital.

You tell me, is there a business model that works for a small rural hospital which is not volume-based? I can see it working for

the primary care provider, but I don't see a nonvolume-based business model working for a rural hospital.

Mr. CAVANAUGH. I think, if you are looking for that, our best hope is probably the Accountable Care Organization with the ACO being a primary player in that. And, as I mentioned in my testimony, we have two different programs to help rural hospitals. We provide them seed capital to help them form an ACO and get into the shared savings program. It is very early, both in the ACO program and in these models that we are running, to——

Senator CASSIDY. I'm sorry. So in that model—I'm sorry. I am going a little bit long.

Senator BLUNT. Go ahead.

Senator CASSIDY. What is the minimum number of patients you would need in order for that rural ACO to work?

Mr. CAVANAUGH. So, the ACO, it doesn't change the minimum number that is in the basic program, which is 5,000 aligned Medicare patients.

Senator CASSIDY. Now that would be for a primary care provider, but 5,000 patients would not support a rural hospital with a CT scan and an OR, et cetera. So do you have the minimum number to maintain a certain X number of hospital beds?

Mr. CAVANAUGH. I'm sorry. I should've been clear. Five thousand is the minimum to getting to the ACO program, the shared savings program. You are asking from an actuarial standpoint, do we have some sense of what the aligned lines would be needed, and I don't know the answer.

Senator CASSIDY. I can tell you, we cannot make wise decisions regarding public policy unless you have those numbers, because ultimately they have to make money. Unless you can give us some data that there is a business model that works under an alternate payment model, we are wasting our time.

I say that not to scold. I'm just saying that we have to make decisions. We would ask you all to come back with that, if I can ask the indulgence of my chair and ranking member. I yield back. Thank you.

HOSPITAL REIMBURSEMENT

Senator BLUNT. Thank you, Senator.

Anybody have a follow-up question? We maybe have time for one or two other questions, if anybody has one.

Mr. Morris, in response to Senator Moran's question, are you saying you believe there are States that reimburse the total cost of a critical access hospital's operation?

Mr. MORRIS. No, sir. What I was saying is that, and Sean can correct me if I'm getting this wrong, when you set the cost-based reimbursement rate, it is based on historical costs. We just see some fluctuations from State to State in what that initial base is.

But it's more complicated than that, and I can get back to you with more information.

Senator BLUNT. I think we expect you to get back to us on that, but I think the point is well made that these rural hospitals are not in the profit-making business, even if they get 101 percent of the allowable reimbursement. But if there are States that have a formula that allows that, we will be anxious to see which States

are doing that and how they figured out how to calculate everything that is spent by the hospital to operate into their cost basis.

Mr. MORRIS. To respond to Mr. Cassidy's question, too, I would say that we do have examples of hospitals even with low volume that have been able to make it work. I mean, I think it really is situationally dependent. There's a base level of volume you need. I agree with that. But we have some success stories out there where folks have been able to bring primary care aligned with physicians and hospitals in a way to figure out what lines of service they can get into that make sense to that community, arrange relationships with upstream providers that make it work.

So what we would like to do is use our funding to sort of be the connecting of the dots between that, identify those models, and maybe replicate them in other communities.

Senator BLUNT. All right.

Senator MORAN. Thank you, Mr. Chairman. And thank you for helping me ask my question. I appreciate the answer.

This is a home health care question. Some of our hospitals, fewer than used to, provide home healthcare services. But the Affordable Care Act includes a provision that requires Medicare beneficiaries to have a face-to-face encounter with a physician who certifies the need for the home healthcare services.

The implementation of this face-to-face requirement raises lots of concerns with home health care providers, hospital-based or otherwise. And the documentation that is necessary, it sure seems to the providers as unclear. And the backlog of audits is increasing.

There's a real uncertainty as to what the CMS standard is for providing satisfactory face-to-face encounters. Most of the appeals have been overturned in favor of the home health care provider.

My question is, do you see this as a problem? Does CMS have a plan to respond to clear up the confusion, provide certainty, and reduce the backlog?

Mr. CAVANAUGH. Yes, Senator. I think you've put your finger on a challenge that we have been taking on head on. The first thing is, in rule-making last year, we simplified—you're correct that the Affordable Care Act created the face-to-face standard. Our initial rulemaking, in addition, required a narrative from the physician, a narrative writing, which providers found ambiguous. So, we withdrew that requirement.

So, we still have the face-to-face requirement, but not the requirement for a narrative description of the need.

We continue to have dialogue with the home health industry to make sure they understand what we are looking for. We are exploring avenues. Personally, I'm very interested in finding a way to facilitate people making the documentation, because as you say, there are a lot of auditor reviews to these. And some get overturned, but many are upheld. Even when they are upheld, it's often about the documentation and not about whether the service was needed, whether it was provided.

Granted, there's fraud, but I'm not talking about that. I'm talking about a lot of services that were truly needed, truly provided, but poorly documented. I'm trying to find out if there's anything the agency, any role we can play to facilitate that without facilitating bad behavior by a subset of the industry.

Senator MORAN. Thank you for the answer. I appreciate your attitude and approach toward attempting to solve this. It is finding that place in which you don't punish those who are doing the right thing, and you do punish or prevent those who do bad things.

Mr. Chairman, thank you.

Senator BLUNT. Thank you. Thank you to the panel. I'm sure we'll have some questions submitted in writing as well. Appreciate your time today.

NONDEPARTMENTAL WITNESSES

Senator BLUNT. Now we will move to the second panel, and as that second panel is coming up, that panel includes Tim Wolters, the director of reimbursement at Citizens Memorial Hospital in Bolivar, Missouri, and he also is a reimbursement specialist at the Lake Regional Health Center System at Osage Beach, Missouri; Dr. Kristi Henderson, Chief Telehealth and Innovation Officer, University of Mississippi Medical Center in Jackson, Mississippi; Ms. Julie Petersen, the CEO of PMH Medical Center in Prosser, Washington; and Mr. George Stover, the CEO of Rice County Hospital District #1 in Lyons, Kansas.

Thank you all for being here.

Mr. Wolters, if you want to start with your testimony, we will go right down the line.

STATEMENT OF TIM WOLTERS, DIRECTOR OF REIMBURSEMENT, CITIZENS MEMORIAL HOSPITAL, AND REIMBURSEMENT SPECIALIST, LAKE REGIONAL HEALTH SYSTEM

Mr. WOLTERS. Thank you, Chairman Blunt, Ranking Member Murray, members of the subcommittee. I appreciate the chance to discuss current challenges facing rural hospitals.

Again, I am Tim Wolters. I oversee government reimbursement programs at Citizens Memorial Hospital in Bolivar, Missouri, and Lake Regional Health System in Osage Beach, Missouri.

Fifty rural hospitals have closed since January 2010. A rural hospital closure means more than just the loss of access to healthcare for a community. As a rural hospital is frequently the largest employer in town, a closure represents an economic blow as well.

My written testimony provides several examples of what is working in rural hospitals, including quality healthcare at a reasonable price to the Medicare program and programs like the medical home program, which improves the health in our communities. I want to focus my oral comments, though, on four specific challenges rural hospitals face.

First, patient volumes are lower at rural hospitals and often fluctuate significantly on a day-to-day basis, making it difficult to manage staffing levels. My written testimony has a graph on page 3 that shows the daily census at Lake Regional for the month of January, showing significant daily fluctuations, including a high census of 103 patients on January 15 and a low of 66 patients on January 25, a significant fluctuation.

Second, Medicare utilization is significantly higher at rural hospitals than at urban hospitals. The table on page 4 of my testimony shows that urban hospitals average only 30 percent Medicare utilization compared to 42.5 percent at rural hospitals. The challenge of such high Medicare utilization is that Medicare cuts represent a higher percent of our budget, and we have less commercial and managed-care volume to subsidize the Medicare losses.

The third challenge is the cumulative impact of Medicare cuts. The graph on page 5 compares estimates using CMS data of hospital costs versus payments from 2011 through 2023. The top line represents the growth in hospital costs over this time, while the bottom-line represents estimated growth in Medicare payments, factoring in the productivity and fixed cuts under the Affordable

Care Act and the sequestration cut under the Budget Control Act. The difference between the lines represents Medicare's lost reimbursement and it grows annually, exceeding 17 percent by 2023.

The cumulative impact of these cuts over this time period for my two hospitals is estimated to be about $120 million. Beyond all the cuts we have been facing, the recovery audit contractor, or the RAC, program is also draining our hospital resources.

Lake Regional currently has over 500 Medicare inpatient claims languishing at the ALJ level of appeal worth about $3.5 million in Medicare reimbursement.

The final challenge we face is the increasingly complex regulatory environment in which we operate. Page 7 shows six different Medicare prospective payment systems and six different Medicare fee schedules we must manage with each of these systems changing on a regular basis, including changes such as the two-midnight rule that CMS implemented in 2013.

Also, we understand the reason for the change to the IDC–10 this fall, and we've been training extensively for the conversion. But this is one more significant change in our operations that we must implement with scarce funds available.

Both my hospitals were early adopters of electronic health records and have achieved stage 2 status. However, with meaningful use funding nearing an end, and requirements continuing to increase, this has also become an administrative burden for us to keep up with the changes that CMS implements.

In conclusion, with 50 rural hospitals closing since January 2010, Congress must act to prevent further erosion of healthcare in rural communities.

We appreciate congressional action to protect the funding we receive. For example, H.R. 2 eliminates the annual threat of a significant reduction in the Medicare physician fee schedule. It also provides a 30-month extension in the Medicare low-volume and Medicare-dependent hospital programs, and extends the ambulance and home health rural add-ons.

For rural PPS hospitals to survive, Congress must continue to support these programs, in fact, making them permanent. Likewise, rural hospitals should be exempt from sequestration and future Medicare cuts.

We also need continued support for programs like the 340B drug discount program, a lifeline for CMH, which also saves money for the State and the Federal Government.

Finally, grant funding should be made available for rural hospitals to assist with the transition to ICD–10 and the larger conversion to future care delivery and payment models.

Thank you for the opportunity to present this testimony today, and I look forward to answering questions you may have.

[The statement follows:]

PREPARED STATEMENT OF TIM WOLTERS

Chairman Blunt, Ranking Member Murray and Members of the Subcommittee, thank you for the opportunity to discuss current challenges facing rural healthcare providers. According to the Sheps Center at the University of North Carolina, 50 rural hospitals have closed since January 2010. My two hospitals, Citizens Memorial Hospital in Bolivar, Missouri (CMH), and Lake Regional Health System in Osage Beach, Missouri (Lake Regional), are striving not to be included in that statistic.

A hospital closure means not just the loss of access to healthcare for a community. As a rural hospital is frequently the largest employer in the community, its closure represents an economic blow as well. The long-term impact is also significant, as businesses are reluctant to locate in a community without a hospital.

Legislation in recent years requires hospitals to improve quality and patient satisfaction, while receiving less Medicare reimbursement. While all hospitals feel the impact of cuts in Medicare reimbursement, rural hospitals are particularly susceptible to these cuts. Before describing several key challenges rural hospitals face that make them more vulnerable to Medicare cuts, I want to talk about what's working in rural healthcare.

Rural hospitals provide quality care close to home. And, in many cases Medicare spends less on this care in rural hospitals than in urban hospitals. Looking at the most recent data CMS reports on Medicare Spending per Beneficiary, CMH has a ratio of 0.93, while Lake Regional has a ratio of 0.92. Both of these ratios are well below the national average, meaning Medicare spends less on care initiated at these hospitals than at the average hospital. CMH is also exploring the possibility of joining an accountable care organization (ACO) under the CMS ACO Investment Model recently announced. This program offers funds to assist with the large investment required to start an ACO.

Rural hospitals provide personalized care, and focus on the patient's needs. Both CMH and Lake Regional have certified our primary care clinics as patient centered medical homes, which focus on the patient's health, offering care coordination, education, and assistance with self-management of chronic conditions. CMH is participating in the Missouri Medicaid medical home program, with over 1,100 Medicaid patients receiving assistance in managing their chronic health conditions. We have seen measurable improvements in health status since we began offering this program.

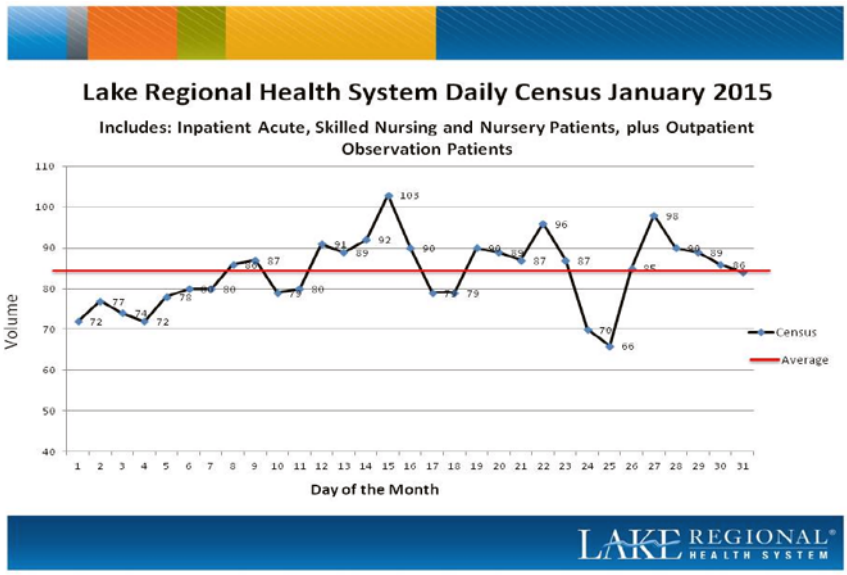
Rural hospitals try to find solutions. Sac-Osage Hospital in Osceola, Missouri, 35 miles north of Bolivar, closed on November 1, 2014, due to declining patient volumes and lack of financial resources. Rather than leaving that community without local healthcare, CMH took over the operations of the ambulance service, primary care clinic, and retail pharmacy, the only pharmacy in Osceola, and operates an outpatient rehabilitation clinic. Our primary care clinic includes walk-in clinic services 12 hours per day, 7 days per week. While the loss of jobs, inpatient beds, and a 24-hour emergency department are all significant, we are trying to find the most feasible solution to make sure healthcare is available to the residents of Osceola and the surrounding area.

But rural hospitals do face many challenges. The four challenges I would like to highlight regarding rural hospitals are patient volumes, Medicare utilization, the cumulative impact of Medicare reimbursement cuts and the increasingly complex regulatory environment in which we operate.

Patient Volumes

Medicare's prospective payment systems generally rely on averages in setting rates applicable to hospitals, with special adjustments for different classifications of hospitals. Rural hospitals are generally smaller than urban hospitals and have lower patient volumes. This creates challenges as we spread fixed costs over lower volumes, trying to keep costs reasonably in line with PPS payment rates. We also have to manage our workforce on a day to day basis as patient volumes fluctuate.

Looking at the past 12 months of data, CMH's lowest average daily census was in July 2014, with an average of 26 patients. Our highest average census occurred in February 2015, with an average of 34 patients, 31 percent higher than the July average. Likewise, Lake Regional had an average daily census of only 39 patients in May 2014, increasing by 49 percent to an average daily census of 58 patients in January 2015. To put this in more perspective, the following graph shows Lake Regional's daily census for January 2015, including traditional inpatients plus skilled nursing, nursery and outpatient observation patients using inpatient beds. The graph shows the month started with a census of 72, peaked on January 15th with a census of 103 patients and hit a low of 66 patients on January 25th. The census rebounded rapidly to a census of 98 patients 2 days later and we ended the month with 86 patients.



The significant volume fluctuations shown in this graph make it extremely difficult to manage our workforce. When possible, we try to manage staffing levels based on the daily census, but if we reduce staff hours too often, we risk employee dissatisfaction. We experience patient care staff leaving the area to work at urban facilities with more stable work hours and patient volumes, and frequently higher pay rates.

Medicare Utilization

Rural hospitals generally have significantly higher Medicare utilization than urban hospitals. The American Hospital Association provided the table on the next page, showing Medicare and Medicaid discharges for urban hospitals compared to several subsets of rural hospitals.

Fiscal year 2013 Medicare and Medicaid Discharges by Hospital Type

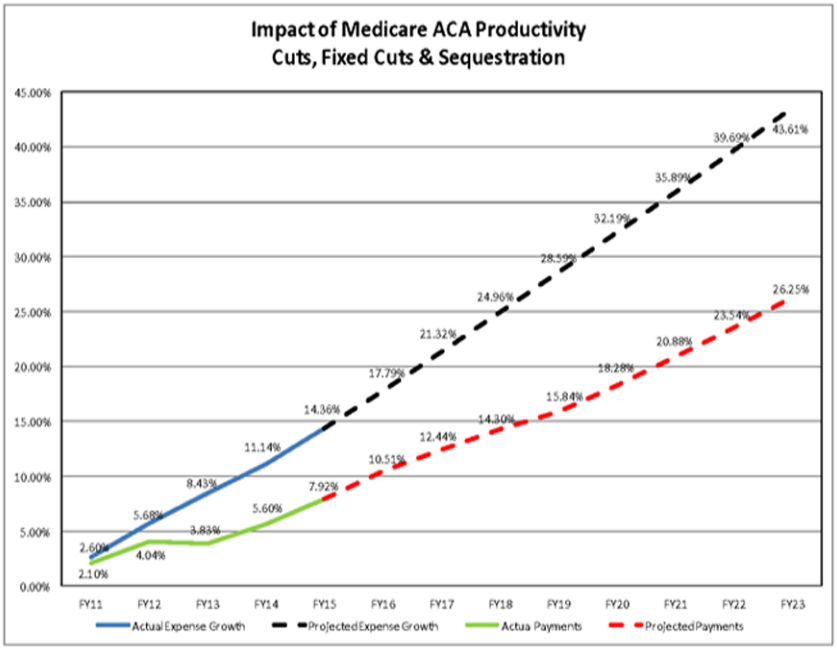
	Number of Hospitals	Medicare Discharges	Medicare Discharge Percent	Medicaid Discharges	Medicaid Discharge Percent	Total Discharges
All Hospitals	4,683	9,583,416	31.5	3,872,807	12.7	30,425,687
Urban	2,565	8,035,725	30.0	3,354,041	12.5	26,786,587
All Rural	2,118	1,547,691	42.5	518,766	14.3	3,639,100
CAH	1,202	298,666	49.4	64,825	10.7	604,217
MDH	192	171,974	48.5	50,784	14.3	354,279
SCH	377	533,742	41.4	182,658	14.2	1,289,173
Other Rural	347	543,309	39.0	220,499	15.8	1,391,431

Source: fiscal year 2013 Medicare cost report data from CMS HCRIS file, 1st quarter 2015 update. Note the 'CAH' category includes rural CAHs only—urban CAHs are in the urban category. The 'Other Rural' category includes only rural hospitals with no special payment status (i.e., non-SCH, non-MDH, non-CAH).

The table shows urban hospitals average only 30 percent Medicare utilization, while rural hospitals average 42.5 percent Medicare utilization. Every classification of rural hospitals averages significantly higher Medicare utilization than urban hospitals. In fact, rural hospitals average higher Medicaid utilization as well. During this same time period, CMH had 38.7 percent Medicare utilization while Lake Regional had 47.0 percent Medicare utilization. The challenge of such high Medicare utilization is that cuts to the Medicare program represent a higher percent of our budget. And, because of the high Medicare utilization, we have less commercial and managed care volume available to subsidize the Medicare losses.

Cumulative Impact of Medicare Reimbursement Cuts

Lower overall volumes and higher Medicare utilization make it particularly difficult for PPS hospitals to adjust to the ongoing and increasing Medicare cuts. The largest ongoing cuts affecting PPS hospitals are the productivity and fixed cuts under the Affordable Care Act, as well as the 2 percent sequestration cut that started April 1, 2013. The graph on the next page compares actual and projected growth in costs and payments for PPS hospitals from fiscal year 2011 through fiscal year 2023. The top line shows actual and projected growth in costs using CMS projected market-basket inflation factors. The bottom line shows these market-basket inflation factors, reduced by required productivity and fixed cuts under the ACA, and sequestration cuts under the Budget Control Act, and thus represents the expected growth in Medicare payments over this same time period.



The widening gap between the lines demonstrates the increasing pressure PPS hospitals will feel to reduce expenses, or increase charges to other third parties, to make up for the escalating Medicare cuts. The gap grows annually, and is expected to exceed 17 percent by 2023. The cumulative impact of these cuts over this 13-year period is estimated to total approximately $43 million for CMH and approximately $78 million for Lake Regional.

Note that the cuts reflected in the graph represent only a portion of the cuts PPS hospitals are experiencing or soon will experience under the ACA and other legislation. Other cuts or funding lapses not measured in the graph include the following:

—Effective for fiscal years beginning on or after 10/1/12, Medicare bad debts are reimbursed at 65 percent of the actual bad debt

—Effective 1/1/13, Medicare outpatient hold harmless reimbursement for rural hospitals was allowed to expire

—Effective 10/1/13, cuts in Medicare disproportionate share payments began

—Effective 10/1/13, CMS implemented a 0.2 percent Medicare cut because they felt the 2-midnight rule would result in more inpatient admissions, although it hasn't

—Effective 1/1/14, sole community hospitals experienced a significant reduction in TRICARE payments for inpatient services

—Effective 10/1/14, a 1 percent Medicare cut for the lowest quartile of PPS hospitals with high rates of hospital-acquired conditions

—Effective 10/1/17, cuts in Medicaid disproportionate share payments will begin which will total $43 billion by 2025

—Effective 10/1/17, the Medicare-dependent hospital and low-volume hospital payment provisions recently extended in HR 2 will be at risk of expiring

Beyond all of these legislative and regulatory cuts and funding lapses, PPS hospitals are also experiencing the end of the cash flow cycle under the electronic health records meaningful use program. The meaningful use program generated $6 to $8 million in funding for PPS hospitals the size of CMH and Lake Regional, funds that were vital to reimburse us for the heavy investments made on meaningful use technology. However, those funds helped mask the impact of the ACA and other cuts that took effect during the past few years and now that meaningful use funds are diminishing, the full impact of other cuts is being felt. And, hospitals that do not maintain their status as meaningful users risk incurring penalties under the meaningful use program.

Finally, the recovery audit contractor (RAC) program has consumed extensive hospital resources to manage those requests in recent years and appeal the excessive denials issued by the RACs. Although activity has diminished while CMS works on the new round of RAC contracts, hospitals continue to deal with a huge backlog of RAC appeals. Lake Regional currently has over 500 claims in the RAC appeals pipeline, with approximately $3.5 million in reimbursement tied up in this process. There are a number of other similar programs operated by Medicare, Medicaid and other payers. At CMH, for example, we have experienced 17 denials by Humana's Medicare HMO plan where the admission was preauthorized, but subsequently denied several months after the patient was discharged.

Increasingly Complex Regulatory Environment

Those not involved in day-to-day hospital operations may assume a PPS hospital learns to operate under a prospective payment system and ongoing operations are not that difficult. The reality is that a PPS hospital must learn multiple payment systems to ensure accurate payment for services to Medicare patients. There may also be significant variations in payment systems for Medicare managed care plans, State Medicaid plans, Medicaid managed care plans and other payers. For example, CMH must maintain medical records and learn the billing requirements to ensure compliance with the following Medicare prospective payment systems and fee schedules:

—Inpatient acute care PPS
—Inpatient psychiatric PPS
—Inpatient skilled nursing PPS
—Outpatient PPS
—Home health PPS
—Hospice PPS
—Physician fee schedule
—Outpatient rehabilitation fee schedule
—Outpatient laboratory fee schedule, for tests not bundled under outpatient PPS
—Ambulance fee schedule
—Durable medical equipment fee schedule
—Pharmacy fee schedule

The value-based purchasing and other quality programs under the ACA and other legislation have increased the need for hospitals to maintain data on various patient indicators and ensure prompt reporting of the data. In fact, CMH has two full-time nurses spending substantially all of their time on quality reporting data collection and verification. Likewise, CMS changes billing and documentation requirements on a regular basis, making it essential hospitals monitor such developments to ensure we remain in compliance, and ensure we don't miss out on vital reimbursement for the services we render. A well-known example of such changes is the 2-midnight rule CMS implemented on October 1, 2013. CMS has also been implementing significant changes in the outpatient PPS as well, in particular bundling many laboratory tests into the PPS rate. These are just two examples of the ongoing changes in payment systems we must educate our staff about and ensure we implement compliantly.

Beyond the payment systems themselves, a new coding system takes effect October 1, 2015. While we understand the reason for the change to ICD–10, and have been training extensively for the change, this is one more significant change in our operations that must be implemented, with scarce funds available for the implementation.

Both of my hospitals were early adopters of electronic health records and have achieved Stage 2 status. However, with the funding drying up and the requirements continuing to advance, this has also become an administrative burden to keep up with the changes CMS implements.

The complex regulatory environment also affects our physicians. While recruiting physicians to rural areas is a longstanding problem, the complex environment of im-

plementing electronic health records, ICD–10 and various quality reporting programs means most physicians are unwilling to practice in rural areas unless a hospital is willing to manage their practice and ensure income stability. In urban areas, independent physicians can join larger clinics with the expertise to manage these complex issues outside of a hospital. In rural areas, these large clinics do not exist, with the hospital taking on the role of managing clinic operations on behalf of most physicians.

The Future for Rural PPS Hospitals

With 50 hospitals closing since January 2010, Congress must act to prevent a further erosion in the availability of hospital services in rural America. We appreciate Congressional actions to protect the funding we receive. For example, HR 2, the Medicare Access and CHIP Reauthorization Act of 2015, eliminates the annual threat of a significant reduction in the Medicare physician fee schedule. The legislation also provides a 30-month extension in the Medicare low-volume and Medicare-dependent hospital programs, and extends several other rural programs. Finally, the legislation includes an additional 6-month delay preventing post-payment patient status reviews under the 2-midnight program. We greatly appreciate the support Congress has shown for these rural programs, as well as the delay in the 2-midnight patient status reviews.

For rural PPS hospitals to continue to survive, we need Congress to continue to support these rural reimbursement programs, in fact, making them permanent. Likewise, rural hospitals should be exempted from sequestration and any future cuts to Medicare programs. We also need continued support for programs such as the 340B drug discount program, a lifeline for hospitals such as CMH, which also saves money for the State of Missouri and the Federal Government.

Finally, grant funding or funding similar to meaningful use funds should be made available to rural hospitals to assist with the transition to ICD–10 and the larger transition of rural hospitals into future care delivery and payment models. This could include expansion and extension of programs such as the CMS ACO Investment Model mentioned previously, and Federal funding for Medicare and Medicaid medical home programs.

Thank you for the opportunity to present this testimony today and I look forward to answering any questions you may have.

Senator BLUNT. Thank you, Mr. Wolters.

Dr. Henderson.

STATEMENT OF DR. KRISTI HENDERSON, CHIEF TELEHEALTH AND INNOVATION OFFICER, UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

Dr. HENDERSON. Chairman Cochran, Chairman Blunt, Ranking Member Murray, and distinguished members of the subcommittee, it is my pleasure to join you today to discuss how telehealth is improving healthcare in rural communities.

My name is Kristi Henderson, and I am a nurse practitioner and serve as the Chief Telehealth and Innovation Officer at the University of Mississippi Medical Center in Jackson.

Mississippi ranks at the bottom for overall health, obesity, heart disease, diabetes, and preventable hospitalizations. More than half of Mississippi's 3 million citizens live in a rural community and almost a quarter live at or below the Federal poverty level. Two-thirds of Mississippi's hospitals are located in rural areas and lack sufficient resources in specialty care.

Despite these facts, telehealth in our State is increasing access to healthcare and improving outcomes and lowering costs. The UMMC Center for Telehealth began in 2003 with the tele-emergency program connecting critical access hospital emergency departments to physicians at our trauma center. Twelve years later, telehealth allows us to provide over 35 medical specialties to 166 sites around the State, including community hospitals and clinics, mental health facilities, schools and colleges, corporations, prisons,

and even in patients' homes. We connect to sites in 52 of the States' 82 counties and serve an average of 8,000 patients a month.

Since 2003, we have been awarded over $9.7 million in Federal grants to purchase devices, conduct work force training, and enable the technology that we use to serve patients daily. This early funding allowed us to test delivery systems, areas of practice, and service locations in order to craft an effective and impactful model worth replicating.

Without early critical support from USDA, HRSA, FCC, and others, our network would've been very slow to deploy, taking the longest to reach those with the most need. Today our system is completely self-sustaining.

A critical factor to our continued sustainability is the reimbursement parity available in Mississippi. Prior to 2013, insurance companies in Mississippi did not reimburse for telehealth services. We argued that Mississippi would ultimately save money if they did, and undertook a series of pilot projects to prove it. We were successful.

In 2013 and 2014, Governor Bryant signed legislation mandating that health insurance companies reimburse for telehealth services at the same rate as in-person services. These policy changes were the catalyst for the rapid growth of our system. While increased reimbursement may cost more in the short term, years of data from our State, and numerous others, prove that the cost savings achieved through better chronic disease management, fewer ER visits, and aggressive preventive care, far outweighed expenditures.

Given the success that we have seen in Mississippi, I can only imagine the exponential impact of offering similar Federal parity for telehealth.

I commend CMS for opening new code sections for reimbursement and hope the committee will encourage them to expand coverage for more services and more communities, be they rural or urban.

Without reliable connectivity, we cannot serve rural patients. Thanks to support from Universal Service Funds and our telecom partners, we are able to bring much-needed healthcare to rural Mississippi. It is this connectivity, enabling remote patient monitoring in the home, that is changing lives in Ruleville, Mississippi.

Last fall, we launched a research pilot aimed at managing 200 uncontrolled diabetics through aggressive in-home monitoring and intervention. Once enrolled, patients are sent home with an electronic tablet that monitors glucose readings daily, provides educational information, and transmits health data to specialists monitoring them hundreds of miles away.

For the first time, these patients have access to a medical team dedicated to their care—ophthalmologists, endocrinologists, pharmacists, nutritionists, diabetic educators, and nurses. Preliminary results show that the majority of patients have already met or exceeded the goals that were set for the end of the study. With one exception, none of our patients have gone to the ER or have been admitted to the hospital for their diabetes. The results are improved care at a reduced cost.

So we look forward to working with the committee and would like you to consider these few points.

The need to test reimbursement parity at the Federal level, particularly for remote patient applications: The only way for us to know if the success of pilots like ours can be replicated at the Federal level is to test it. Now is the time for CMS to pilot new reimbursement parity models for telehealth, especially in-home monitoring where impact is the greatest.

The need for continued coordinated Federal support for telehealth: While our network has become self-sustaining, it will not be complete until we reach every Mississippian. The need for Federal funding remains, and efforts to coordinate opportunities across the agencies should be encouraged.

The need to remove geographic barriers for reimbursement: Rural or urban, telehealth is a powerful tool in improving access to care and should be incentivized. We recommend that geographic restrictions for CMS reimbursement be removed.

Then lastly, the need for continued support for Universal Service Funds: A reduction in any of the USF funding will not only impact current operations but will significantly hinder our efforts to offer remote patient monitoring in rural communities. Funding should be protected.

Our mission is to increase access to health care, improve outcomes, and reduce cost. Telehealth allows that to happen.

I thank the subcommittee for the opportunity to testify today and look forward to answering your questions. Thank you.

[The statement follows:]

PREPARED STATEMENT OF DR. KRISTI HENDERSON

Chairman Cochran, Chairman Blunt, Vice Chairwoman Mikulski, Ranking Member Murray and other distinguished Members of the Committee, it is a pleasure to appear before this subcommittee to discuss how telehealth is improving healthcare in rural communities. I thank the Subcommittee, and especially my Senator, Chairman Cochran, for the opportunity to testify and look forward to a robust discussion.

My name is Kristi Henderson, and I serve as Chief Telehealth and Innovation Officer at the University of Mississippi Medical Center in Jackson. I also bring my clinical experience as a nurse practitioner to my testimony. I am pleased to tell you that telehealth in our State is increasing access to care in rural communities, improving health outcomes and lowering costs.

Telehealth was born out of necessity. Patients living in rural areas always have lacked access to healthcare, and, even today, those who are not able to travel often receive inadequate care, or no care at all. Many patients are not able to see a specialist or get the treatment they need without traveling long distances. Long gone are the days when each small town had its own "Jack of all trades" doctor who could deliver babies, set broken bones and check on Grandma's aching back. While patients in urban areas may be located in closer proximity to medical services, the waiting time for appointments with specialists can be several weeks, resulting in increased severity of disease equivalent to that in the rural areas.

Why is this?

The physician shortage is partially to blame. The Association of American Medical Colleges (AAMC) predicts that by the year 2020, there will be a national shortage of more than 90,000 doctors, including 45,000 primary care physicians.[1] Rural communities rely on family medicine physicians because they are often the only healthcare providers in the area, yet in the last decade, the number of medical school graduates choosing to specialize in family medicine has declined.[2] Of those

[1] Association of American Medical Colleges, 2010.

[2] Rosenblatt, Roger A.; Chen, Frederick M.; Lishner, Denise M.; Doescher, Mark P. The Future of Family Medicine and Implications for Rural Primary Care Physician Supply. WWAMI Rural Health Research Center. Final Report, #125 (2010).

who do elect to study family medicine, only 11 percent choose to practice in rural areas.[3]

Chronic disease is another major challenge, particularly for poor, rural Americans. A review of data provided by the CDC reveals that approximately 117 million people—about half of all adults in the U.S.—have one or more chronic health conditions. More than 75 percent of healthcare costs are due to chronic conditions, nearly $7,900 for every American with a chronic disease.[4] [5] Approximately, 1 in 5, or 2.6 million Medicare patients are readmitted to the hospital within 30 days of discharge due to chronic conditions, which generates costs of over $26 billion each year. In Mississippi alone, seven of the leading causes of death in 2011 were chronic disease-related.

Due to limited local medical services and lack of transportation, patients are often unable to access vital primary care services that focus on prevention and management of chronic illnesses, which leads to inadequate continuity and coordination of care. The result is inflated healthcare costs, poor outcomes and repeated readmissions. Telehealth is a critical tool in addressing these challenges, one that Mississippi has used with great success to increase access to healthcare and reduce cost.

The Telehealth Solution

In its infancy, telehealth simply connected hospital sites to rural clinical sites, linking health providers to each other and bringing much needed services to remote areas. Telehealth, however, can be used in many different settings beyond the traditional hub and spoke model. From corporations to correctional facilities, telehealth is providing access to care and reducing costs for both providers and patients.

—In the workplace—In 2011, 11 percent of employers with at least 5,000 employees said that they have a telehealth program in place, up from 5 percent in 2010, according to a study by Mercer. Participating employers are seeing productivity savings of up to three hours and an average cost savings of $55 in medical costs per visit.

—In correctional facilities—From a baseline of 94,180 transports made annually from correctional facilities to emergency departments at a cost of $158 million, telehealth technologies could avoid almost 40,000 transports with a cost savings of $60.3 million a year. Further, from an annual baseline of 691,000 physician office visits at a cost of $302 million, telehealth could avoid 543,000 inmate transports with a cost savings of $210 million.[6]

—In schools—School-based telehealth provides access to healthcare for students to receive needed healthcare, mental health, chronic disease management and other care in schools. In an Onondaga County, New York, remote diabetes care program, students' A1C levels were lowered and urgent visits and hospitalizations during the course of the study were reduced.[7] The availability of telehealth in schools has been shown to reduce students' absenteeism, enabling healthy children to become better students.[8]

—In nursing homes—From a baseline of 2.7 million transports made annually from nursing home facilities to emergency departments at a cost of $3.62 billion, telehealth could avoid 387,000 transports with a cost savings of $327 million. In addition, of the 10.1 million physician office visits made annually from nursing facilities at a cost of $1.29 billion, telehealth could avoid 6.87 million transports with a cost savings of $479 million.[9] [10]

—Into the home—Remote patient monitoring is a form of telehealth that is being used to address chronic disease. A national home telehealth program started by the Veterans Administration resulted in a 25 percent reduction in numbers of

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[3] Chen, F., Fordyce, M., Andes, S., & Hart, L. (2010). Which Medical Schools Produce Rural Physicians? A 15-Year Update. Academic Medicine, 594–598. Retrieved April 17, 2015, from http://www.siumed.edu/academy/jc__articles/Distlehorst__0410.pdf.

[4] Centers for Disease Control and Prevention. 2009. Retried on March 27, 2014, from http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm.

[5] Center for Disease Control and Prevention. Chronic disease overview: Costs of chronic disease. 2012. Available at http://www.cdc.gov/nccdphp/overview.htm.

[6] Vo, Alexander. "The Telehealth Promise: Better Health Care and Cost Savings for the 21st Century." AT&T Center for Telehealth Research and Policy, no. May 2008 (2008): 10. http://telehealth.utmb.edu/presentations/The Telehealth Promise-Better Health Care and Cost Savings for the 21st Century.pdf.

[7] Daniels, Stephen R. School-centered telemedicine for type 1 diabetes mellitus. The Journal of Pediatrics. September 2009; 155(3): A2.

[8] McConnochie KM, Wood NE, Herendeen NE, ten Hoopen CB, and Roghmann KJ. Telemedicine and e-Health. June 2010, 16(5): 533–542. doi:10.1089/tmj.2009.0138.

[9] Center for Information Technology Leadership Partners HealthCare System, Inc., 2007.

[10] State Health Care Spending Project, 2013. Pew Charitable Trusts and John D. and Catherine T. MacArthur Foundation. www.pewstates.org.

bed days of care, a 19 percent reduction in numbers of hospital readmissions and mean satisfaction score rating of 86 percent after enrollment into the program. This is just one example of how remote monitoring can lead to a dramatic reduction in costs and an equally dramatic increase in quality.[11]

Telehealth in Mississippi

Nowhere in this great Nation are healthcare challenges greater than in Mississippi. Not only do we lead the Nation in prevalence of multiple chronic diseases, we also have the lowest number of doctors per capita of any State in the Nation. Add to that persistent poverty and low educational achievement spread throughout a rural, agrarian State, and you can begin to see why telehealth is our best option for changing health outcomes for Mississippi.

Mississippi has a population of roughly 2.9 million people, with more than 1.6 million people living in a rural community and 23 percent living at or below the Federal poverty level.[12] [13] Mississippi ranks the worst in the country for overall health, obesity, heart disease, diabetes, infant mortality and preventable hospitalizations.[14] We rank fifty-first in the Nation for deaths before the age of 75 years resulting from conditions that could have been prevented with timely quality healthcare.[15]

Of Mississippi's ninety-nine hospitals, seventy-two hospitals are located in rural areas and suffer from the lack of resources and corresponding access to care common in rural areas. The State's expenditure on healthcare exceeds the national average with 32 percent of the budget being spent on healthcare. Almost half of payments to healthcare providers in Mississippi were from Medicare and Medicaid.

UMMC Center for Telehealth

The University of Mississippi Medical Center in Jackson is home to Mississippi's only academic medical center, only Children's hospital, only transplant program and only Level One trauma center. We have the State's only allopathic medical school, dental school and pharmacy school, and we are the major player in clinical and translational research. While these programs and services are more readily accessed by those living in the Jackson area, we know that, in order to make progress toward improved health statewide, we have to bring our healthcare experts to patients in the communities where they live.

The UMMC Center for Telehealth got its start over 10 years ago with the TelEmergency program. Today, UMMC connects 15 emergency departments in rural hospitals with our Level One trauma center at UMMC. Through this system, UMMC's emergency medical team consults with rural providers using a real-time, video and audio connection, interacts with the patient and gives guidance to the provider regarding treatment options. Our TelEmergency program has resulted in a 25 percent reduction in rural emergency room staffing costs, a 20 percent reduction in unnecessary transfers and has produced patient outcomes in rural hospitals that are on par with that of our academic medical center.

Twelve years later, using a similar audio/video platform, the UMMC Center for Telehealth is providing over 35 medical specialties in 165 sites around the State, including community hospitals and clinics, mental health facilities, FQHCs, schools and colleges, mobile health vans, corporations, prisons and patients' homes. The UMMC Center for Telehealth connects to sites in 52 of the State's 82 counties and serves an average of 8,000 patients per month.

Our statewide telehealth network was built with funds from State, Federal and private grants. Since 2003, we have received over $9.7 million from Federal sources to purchase devices, conduct workforce training and enable the technology that we use to serve patients daily. This funding allowed us to test new delivery systems, new areas of practice and new service locations in order to craft an effective and impactful model worthy of replicating. The grant funding allowed us to prove concepts and build statewide coalitions while working on policy changes necessary to sustain the program outside of the grant funding. Today, I am pleased to report that our system is completely self-sustaining. Without early, critical support from FDA, HRSA, FCC and others, however, our network would have been very slow to deploy, if ever, taking the longest to reach those with the most need. I encourage the com-

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[11] Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions. Adam Darks, Patricia Ryan, Rita Kobb, Linda Foster, Ellen Edmonson, Bonnie Wakefield, Anne E. Lancaster. Telemedicine and e-Health. December 2008, 14(10): 1118–1126.

[12] U.S. Census, 2010.

[13] Rural Assistance Center, 2013.

[14] Kaiser State Health Facts, 2009.

[15] Commonwealth Fund State Scorecard, 2014.

mittee to continue to provide incubator funding for telehealth, including workforce training opportunities, and to facilitate coordination among Federal partners to best leverage limited Federal funds.

As we worked to expand telemedicine services, we ran into several laws and regulations that complicated its delivery. The first obstacle we encountered was the financial disincentive to practice telemedicine. Prior to 2013, insurance companies in Mississippi did not reimburse for telehealth consults in a way that made it an attractive alternative to a clinic visit. We argued that Mississippi would ultimately save money by reimbursing for telehealth and undertook a series of pilots to prove it. We were successful.

In 2013, Governor Phil Bryant signed legislation mandating both public and private health insurance companies reimburse for telehealth services at the same rates as in-person services. The following year, the Governor signed legislation mandating equal reimbursement coverage for store-and-forward and remote patient monitoring services. Thanks to the Governor's leadership in clearing the barriers to reimbursement parity, Mississippi is now recognized as a leader in telehealth. Mississippi has received a grade of "A" for telehealth parity reimbursement policies by the American Telemedicine Association.

These changes at the State level were the catalyst for the rapid growth of our State's telehealth system. Given the cost reductions that we have seen in Mississippi through mandated parity, I can only imagine the exponential impact of offering similar Federal parity for telehealth. While increased reimbursement may cost the government more in the short term, years of data from our State and numerous others prove that the costs savings, achieved through better chronic disease management, fewer ER visits and aggressive preventative care, far outweigh these expenditures. I would encourage this Committee and CMS to implement telehealth testing, research and demonstration projects, including through CMMI, with the ultimate goal of expanding reimbursement where health status is improved and cost savings are greatest.

Testing telehealth to demonstrate effectiveness of care and cost efficiencies is especially important as CMS currently restricts reimbursement for telehealth to patients who receive treatment in a Rural Health Professional Shortage Area or in a county that is not considered part of a Metropolitan Statistical Area. Within the Department of Health and Human Services alone, there are numerous definitions of what "rural" means, leading to confusion. Many urban areas also are medically underserved and would benefit greatly from access to telehealth. Therefore, I would request that CMS consider removing geographic restrictions for telehealth reimbursement.

Another obstacle we encountered was connectivity. Due to the largely rural nature of our State, we could not take for granted that support for telehealth services would be available at the level we required, or frankly, at all. In order to achieve the connectivity required, we partnered with telecommunications companies from around the State to maximize existing resources and leverage the strength of incumbent utilities in the areas where they serve. Thanks to support from the Universal Service Fund and our partners across the State, we are able to bring much needed, life changing healthcare to rural Mississippi. Nothing tells this story better than the success of our Diabetes Telehealth Network pilot.

In 2012, diabetic medical expenses in Mississippi totaled $2.74 billion, according to the American Diabetes Association. Because Mississippi leads the Nation in chronic disease, we wanted to begin disease management where it is the worst. Ruleville, Mississippi, is ground zero for diabetes. Sunflower County, where Ruleville is located, has one of the highest percentages of diabetics per capita of any county in the country. This means repeated visits to the ER, amputations and early death for too many members of this community.

Last fall, the UMMC Center for Telehealth partnered with the Governor, Intel-GE Care Innovation, C Spire and the North Sunflower Medical Center to develop a research pilot with the ambitious goal of managing 200 uncontrolled diabetics through aggressive in home monitoring and intervention. The centerpiece of the partnership is a population based healthcare model that leverages telehealth technology delivered over state-of-the-art fixed and mobile broadband connections. Its goal is to improve the health of participants while reducing the total cost of care. Once a patient meets criteria to be admitted to the pilot, he or she is sent home with a tablet that monitors glucose readings daily, provides educational health information and transmits vital health data to specialists monitoring them in real time. For the first time, these patients have access to a team of professionals dedicated to their care—ophthalmologists, endocrinologists, pharmacists, nutritionists, diabetic educators and nurses. Many of our patients have never used a computer

and some cannot read beyond a sixth grade level. Despite these challenges, our patients are thriving.

Of the 93 patients currently enrolled in the pilot, all report that their disease is under control for the first time and that they have lost weight and are feeling better. While our goal was for 75 percent of patients to reduce their hemoglobin A1C levels by 1 percent in the first year, study results show that after only 6 months, the average reduction in A1C levels among participants is almost 2 percent. In addition, with the exception of one patient who needed to be hospitalized at the time of enrollment, none of our participants have gone to the ER or been admitted to the hospital for their diabetes.

This program highlights the value of daily, in-home monitoring for improving health outcomes and reducing costs, particularly for patients with chronic diseases. We appreciate CMS's recent work to open new code sections for chronic care management, and request that CMS consider expanding Medicare reimbursement for remote patient monitoring.

The Future of Telehealth

As we look to the future, I urge the Committee to consider these issues:

—*The need to test reimbursement parity at the Federal level, particularly for remote patient applications*.—State legislation mandating payment equality was the driver for increased deployment of telehealth technology to underserved areas. What this robust marketplace proves is that reimbursement parity increases access to care in rural communities, improves health outcomes in these regions and saves money. The only way to know if successes at the State level can be replicated at the Federal level is to test it. Now is the time for CMS to pilot reimbursement parity models for these technologies, especially in-home monitoring where impact is greatest.

—*The need for continued and coordinated Federal support for telehealth infrastructure development, workforce training and demonstration projects*.—The infrastructure of our telehealth network has been built primarily with grant funding aimed at providing healthcare to rural communities. But for this funding, the equipment and technology necessary for telehealth would not have been possible. While our network has become self-sustaining, it will not be complete until we reach all four corners of the State. The need for Federal funding remains, and efforts to coordinate opportunities across agencies should be encouraged.

—*The need to remove geographic barriers for reimbursement*.—As powerful as telehealth is in tackling the challenges of rural health, it can be just as effective in urban areas that lack access to care. Furthermore, the definition of "rural" is inconsistent across Federal agencies, thereby limiting the utilization of telehealth. We request that geographic restrictions for CMS reimbursement be removed.

—*The need for continued support of USF*.—Today, in rural Mississippi, there is connectivity thanks to the success of the Universal Service Fund's High-Cost program. A reduction in funding will not only impact current operations, but will significantly impede our efforts to grow remote patient monitoring and hinder connections between patients and medical professionals.

—*The mission of the UMMC Center for Telehealth is to increase access to healthcare, improve outcomes and reduce costs*.—Rural communities that have limited medical services can now take advantage of healthcare services delivered to their community virtually. Providing our State with improved emergency medical services and specialty healthcare through telemedicine technology, UMMC Center for Telehealth is eliminating barriers to quality healthcare for Mississippians.

I thank the subcommittee for the opportunity to testify today and look forward to answering any questions you may have.

Senator BLUNT. Thank you, Dr. Henderson.

Ms. Petersen.

STATEMENT OF JULIE PETERSEN, CHIEF EXECUTIVE OFFICER, PMH MEDICAL CENTER

Ms. PETERSEN. Chairman Blunt, Ranking Member Murray, and members of the subcommittee, thank you for the invitation to testify today. My name is Julie Petersen, and I'm the administrator of PMH Medical Center, a critical access hospital located in Prosser, Washington, a community of about 6,000 people.

PMH is organized as a public hospital district, and we serve about 68,000 rural residents in two counties and five small towns. The mission of rural health care providers like PMH is to ensure access to high-quality, affordable care for populations that are challenged disproportionately by distance, poverty, age, chronic conditions, and cultural barriers.

Many of our patients do not have reliable transportation, paid sick leave, and the other resources that allow them to travel to receive care outside of their communities. In short, rural communities are older, sicker, have poor health status, and face significant economic challenges.

It's never been easy to provide access to high-quality care in these communities, and it's more difficult today than ever before.

As is the case with most rural communities and hospitals, PMH is more than just a hospital. We are the backbone of the community health system. What you may think of as traditional hospital activity makes up just slightly more than a quarter of our business today.

In my written testimony, I included an extensive list of the non-hospital services that we provide, everything from primary care to our 911 EMS service. We are a fully integrated delivery system dedicated to meeting the health needs of our community in a coordinated way.

But the current reimbursement system does not recognize that reality. Reimbursement is siloed, and there are as many ways that we get paid as there are services we provide. This makes sustaining a coordinated health system for our community very difficult.

For example, I need to be moving forward to create medical homes for my residents. I need to be integrating behavioral health and medical health in my rural health clinics. But there are so many reimbursement variables that I cannot assure my board that we can sustain these programs. The current fragmented financial system destabilizes rural health.

Another challenge we face is that many people in our area remain uninsured. That's despite the fact that our State had a very successful Medicaid expansion program. We provide coverage to 535,000 additional Washingtonians through expanded Medicaid, and the health insurance exchange enrolled another 170,000 Washingtonians. These efforts need to continue.

Rural communities also face greater shortages of healthcare professionals than their urban counterparts. As a CEO, physician recruitment is a constant activity for me. I have an aging work force, and our doctors are still required in many cases to participate in call, which is not the case in urban areas. So they work very, very long hours, and they see far more complex cases in the clinic setting.

HRSA programs like the National Health Service Corps and the nurse training initiatives enable many communities like mine to attract the providers that they need.

These challenges, our unique population, the fragmented financial system, and work force shortages make it very difficult for rural healthcare facilities to survive. We need flexibility.

In Washington, as Senator Murray pointed out, we've identified about 10 very small critical access hospitals that might be facing imminent closure. That awareness has led the association, the Department of Health, the State Office of Rural Health, and others to begin seeking new delivery system models.

Our goal in Washington is to develop and test one of these new models within the next 12 to 18 months. That is a very ambitious timeline, but it is justified in view of the plight of some of these smallest facilities.

One invaluable tool in this effort is the CMMI grant that provides $65 million to the State for the Healthier Washington Initiative. We also have two rural hospital collaboratives that are funded in part through HRSA grants that are working with critical access hospitals and rural clinics to pioneer rural network development and outreach.

The Federal Office of Rural Health Policy and the Washington Office of Rural Health have been generous partners in these efforts. We will need continued help from these offices and from CMS if we are to succeed.

Finally, I'd like to take a moment to brag a little bit about the leadership shown by all of our Washington hospitals in advancing quality of care and patient safety. The centerpiece of this effort was an $18 million grant that funded our hospital association's participation in the hospital engagement network. This quality and safety improvement work, this $18 million grant, has generated $235 million in healthcare savings through reduced readmissions, fewer hospital-acquired conditions, and healthier babies.

That's just one example of how our rural hospitals are preparing for a future where measuring quality, efficiency, and service will be essential. We are ready to demonstrate our value to partner hospitals, health plans, and to our patients.

Rural providers are dedicated to ensuring that the people who live in rural communities have access to the highest quality, affordable medical care. I'm optimistic that we can achieve this goal. The programs that we're discussing at this hearing today are valuable tools on that journey. Thank you.

[The statement follows:]

PREPARED STATEMENT OF JULIE PETERSEN

Chairman Blunt, ranking member Murray, and members of the Subcommittee, thank you for the opportunity to testify today on rural healthcare issues.

I am Julie Petersen, CEO of PMH Medical Center in Prosser, Washington, a community of about 6,000 people in the south central part of the State.

PMH is a 25-bed critical access hospital (CAH) with an average daily census of approximately 15 acute, swing and obstetric patients. In addition to providing inpatient and outpatient hospital services, we also employ or contract with 27 physicians and providers in our clinics and hospital.

PMH has a rural health clinic that provides primary care, OB/GYN, medical pain management and limited dental services. We also provide both inpatient and outpatient general, orthopedic, podiatric, gynecological and ear, nose and throat surgical services through our provider-based surgical clinic. PMH provides Level IV trauma and Level III stroke team service.

In addition, PMH provides 24 hours a day, 7 days a week emergency ambulance services to a large, multi-county region using two advance life support ambulances operating out of two stations. We also work closely with our local public health department, community health centers, and other local providers.

PMH operates as a public hospital district governed by a seven-member elected board. Our district serves roughly 68,000 rural residents in Benton and Yakima

Counties. In addition to the services we provide in Prosser, we operate satellite facilities throughout the sparsely-populated parts of our district.

The Good News

There is a lot of excellent healthcare work being done in the State of Washington, much of it with the support of the Federal Government.

Washington State hospitals have been recognized as national leaders in increasing the quality and safety of care in our hospitals. We believe that rural hospitals can and should provide the same high quality care that our larger hospitals provide. Our State's rural hospitals are fully invested in the quality improvement work being advanced collaboratively. We also believe this work must be measured and reported.

Over the last several years, the Washington State Hospital Association (WSHA) has received $18 million in Federal funds to participate in the Hospital Engagement Network/Partnership for Patients initiative established by the Centers for Medicare & Medicaid Services (CMS).

This initiative is a public-private partnership working to improve the quality, safety, and affordability of healthcare for all Americans. The program focuses on making hospital care safer, more reliable, and less costly. In Washington, we have used the funding to come together and share best practices, hire national experts to teach us, report and analyze data to motivate performance, and educate patients.

The return on investment for this program has been enormous: $235 million in reduced healthcare spending.

For example, the State's hospital readmission rate fell dramatically, by almost 12,000, saving more than $110 million. About $10 million was saved by quickly reducing early elective baby deliveries, which can result in harmful and expensive complications.

The program also helped us prevent 23,000 potentially harmful events to patients, including:

—An 89 percent reduction in ventilator-associated pneumonia,

—A 60 percent reduction in pressure ulcers,

—A 38 percent reduction in severe sepsis and septic shock mortality resulting in 175 lives saved,

—17 percent reduction—42 fewer—in Clostridium difficile infections, and

—A 13 percent reduction in catheter-associated blood stream infections.

We greatly appreciate Congress's investment in the Partnership for Patients program and encourage you to keep investing in it. We believe you will continue to see similar return on investment.

In addition to these statewide accomplishments, PMH was awarded a $1.5 million grant from the Center for Medicare & Medicaid Innovation (CMMI) for 3 years. This program utilizes a case manager and the paramedics and EMTs that staff our 911 service to visit patients who have recently been discharged from the hospital, fragile emergency department patients, and to perform follow-up after surgery.

This team works with primary care physicians, home health agencies and family to confirm follow-up appointments, review medications and ensure discharge instructions are being followed. We have seen a reduction in readmissions to the hospital as a result of the program.

Recently, Washington State was also awarded a $65 million CMMI grant to transform healthcare. Called Healthier Washington, the initiative invests in forming connections and active collaboration with Washington's communities, partners and providers to achieve better health, better care, and lower costs.

The initiative's areas of focus include:

—Community empowerment and accountability,

—Redesign of clinical practice,

—Payment redesign, including developing a new payment model for rural care providers, and

—Analytics, interoperability and measurement.

The initiative seeks to improve the care of patients while reducing costs. For example, the initiative will test clinical care models integrating physical and behavioral health for the State's primary care and rural health delivery system.

Challenges Facing Critical Access Hospitals

But while we have much to be proud of, we face serious challenges, as well.

While Washington State has some large population centers such as Spokane and Seattle, a vast amount of our State's land is used for agriculture. In fact, 31 of Washington's 39 counties are considered rural.

PMH is typical of the healthcare organizations that serve rural areas. These organizations represent, in many cases, the entire healthcare delivery system—providing access to a broad spectrum of healthcare services from primary care to hospice,

home health and emergency ambulance services. Their continued viability is critical to the health, welfare and economic viability of these communities.

This has always been a difficult challenge—but, in recent years, it has become even more so.

Characteristics of Rural Populations

Rural communities often have large uninsured and low-income populations. In Yakima County, 25 percent of the population was uninsured in 2012, compared to about 17 percent statewide. Thirty-four percent of the adults in the county were uninsured.

One reason for the higher uninsured rate is that, compared to urban counties, there are fewer large employers in rural areas who provide medical benefits. In addition, many of the uninsured were agricultural workers who work in seasonal jobs.

This population still gets sick, still has babies and still suffers accidents. But, because they did not have insurance, they often did not have a primary care provider and put off routine primary care. That means that when they do need medical attention, they use PMH's emergency room—the most expensive venue for care.

And, because these patients have not been able to pay their medical bills, the cost of their care is passed on to privately-insured individuals in the form of higher insurance premiums.

Rural communities also have greater concentrations of older residents. It is not uncommon in rural hospitals for 80 percent of a hospital's patients to be covered by Medicare and/or Medicaid.

Medicare and Medicaid enrollees are often sicker, can suffer from a number of chronic conditions, and, compared to a healthy 30 year old population, require more expensive medical procedures. This puts extra demands on the delivery system.

In general, the health status of people in rural areas is not nearly as good as in urban areas. For example, according to Washington State Department of Health data, mortality rates are higher in rural areas. Rates for three of the top causes of death—stroke, unintentional injury and self-harm—are higher and increasing rapidly in rural communities. The number of adults who are overweight or obese is also consistently higher in rural areas.

This is especially true in parts of our market area. For example, in Yakima County, diabetes, obesity, and infant and child mortality all exceed the State average. The premature death rate is 26 percent higher than statewide; sexually-transmitted infections are 46 percent higher; and the teen birth rate is twice the State average.

These circumstances present special challenges to providers and can dramatically increase the need for medical services.

Workforce Shortages

In addition, we face workforce shortages in rural areas. Physician recruitment is a full-time job for me and my colleagues. And once we've recruited physicians, keeping them here is even more important. Physicians in rural areas are still routinely required to participate in on-call rotations. That is no longer the case in many urban and suburban settings and can greatly affect a physician's work-life balance.

Our providers—especially those in anesthesia, surgery, the emergency department and primary care—actually work longer hours, including a 24-hour call. They also often work in multiple locations. In primary care, physicians see far more complex patients than their urban counterparts.

Rural hospitals and health clinics also face constant struggles to retain nurses and the other health professionals we need to keep our doors open.

Making matters worse, we have an aging workforce, so keeping the workforce pipeline open and running smoothly is critically important to us. That's especially true for specialty nurses like those who are trained for emergency services and labor and delivery.

Rural health systems, like mine, compete in a national labor market, which means we pay top dollar for primary care doctors, nurses and other health professionals.

Wages and salaries for the healthcare professionals and other workers at PMH account for more than 68 percent of our organization's costs. So, paying national labor rates contributes significantly to the overall cost of care in our community.

Costs of Delivering Services

The cost of prescription drugs, technology and health information technology, like electronic health records, also drives up the cost of medical treatment in Prosser and other rural communities.

PMH participates in the 340B drug discount program, as do 29 of Washington's 39 CAHs. This program, which was expanded in the Affordable Care Act to include

CAHs, enables us to provide affordable prescription drugs to patients who otherwise would not be able to obtain them.

Financing Health Care

Finally, reimbursement models often don't suit sparsely-populated communities like mine. Similar to most CAHs, PMH is an integrated health system. As I noted before, we provide a broad spectrum of services to our community.

Unfortunately, Medicare reimbursement policies fail to recognize this reality. Separate and distinct policies govern reimbursement for hospital, physician, skilled nursing, home health, hospice and other services. While CAHs are paid 101 percent of their allowable costs for hospital services—actually 99 percent after sequestration—payments for these other non-hospital services are not nearly high enough to pay for the true cost of care.

Because of the wide variety of services we provide, we are reimbursed in a myriad of different ways—from fee-for-service to encounter rates, per-diem rates (or daily rates) and percentages of payment based on the cost of providing care.

We also face conflicting incentives and regulations. For example, keeping a patient for more than two midnights but not more than 96 hours and not knowing at the time of admission whether the patient will stay longer than 48 hours but fewer than 96 hours complicates care planning even more.

The two midnight and 96 hour rules are both recent CMS clarifications and changes in policies that impact our reimbursement.

With advances in technology and treatment techniques, inpatient hospital revenue as a percentage of total revenue for healthcare organizations continues to shrink. This is especially important at PMH where inpatient hospital services account for only 27 percent of the organization's revenues. As the demands for healthcare change and more services are performed outside of the hospital, payment models should recognize this shift.

In addition, increasingly complex regulatory requirements have added considerable costs to our administrative structure. Too often, we are expected to comply with rules that may make sense in large urban areas but do not fit the models of care in our rural communities.

In this environment, it is increasingly difficult for rural health systems to remain financially viable and to continue to provide the services their communities need.

Increasing Health Care Coverage

As I mentioned above, the large uninsured populations in parts of our State—including Benton and Yakima counties—has been a major concern for us. That's why hospitals strongly supported efforts to expand Medicaid eligibility and to operate a State-run health insurance exchange.

The availability of coverage through the State's health insurance exchange and through the expansion of Medicaid has led to a dramatic reduction in the number of uninsured Washingtonians. Statewide, the percentage of residents without some sort of insurance has fallen from about 17 percent to 11 percent according to a recent Gallup poll.

Medicaid expansion has resulted in about 7 percent of the State's population enrolling in the program. That's nearly 535,000 residents who now have health coverage and includes more than 5,000 residents of Benton County—about 3 percent of the county's population.

By April 18, 2015, the Health Benefits Exchange had enrolled 170,000 people in individual insurance plans with almost four of five people who bought coverage through the Exchange receiving some subsidy to help pay the cost of monthly insurance premiums.

In Benton County, 3,285 people enrolled in plans though the Exchange, about 2 percent of the population, and 2,660 of them received subsidies. In Yakima County, 4,160 people were enrolled in Exchange plans, and 3,630 of them received subsidies.

For the two open enrollment periods for plan years 2014 and 2015, the Exchange had a robust outreach and enrollment program. During the open enrollment period for 2015, the Exchange supported 1,400 navigators.

In addition, hospitals across the State supported outreach and enrollment efforts employing 240 in-person assisters. In Benton County, I want to applaud the work done by our navigators. They not only enrolled people, but educated them about how to use health insurance and why it is important to have a primary care physician.

Medicaid expansion and the development of the insurance exchange has had a dramatic impact on PMH. For example, in just 1 year, our clinic visits increased by 27 percent. Our hospital is busier than it has ever been. The simple math of cost-based reimbursement is decreasing our cost per beneficiary.

In the first quarter of 2015—compared to the same period a year ago—our adjusted patient days are up 40 percent while our cost per patient day is down 27 percent.

Uncompensated care is another indicator of the impact of coverage expansion. In 2013, as a percentage of revenue, uncompensated care—care for low-income patients that was provided at no cost or with financial assistance—was 7.1 percent. By 2014, it had shrunk to 4.5 percent.

We are seeing new patients who are using their health insurance coverage to see primary care providers—often for the first time. Access to preventive care, routine examinations, and diagnosing chronic conditions are possible for thousands of Washingtonians now because of insurance subsidies and expansion of Medicaid coverage.

Our goal now is to get them into an organized system of care that helps them avoid illness in the first place, and, when they do get sick, treats them early. Achieving all these goals is vastly easier when people have insurance.

We are also working to develop medical home models around the State to ensure care is coordinated and healthcare resources are used wisely. And hospitals like mine are collaborating on a wide variety of other projects ranging from group purchasing of supplies to sharing physician and clinic facilities.

In the long run, I am confident this new access to primary care will create a healthier, more productive population and help people avoid costly hospitalization and other medical procedures.

Finally, it is important to acknowledge that there is a cost for coverage expansion. The Affordable Care Act (ACA) reduced Medicare and Medicaid payments to hospitals across the U.S. to help pay that cost. Washington hospitals' share of that reduction was roughly $4 billion over 10 years.

Workforce Development

The State of Washington has made major investments in programs to train physicians and other providers, and we offer a number of high quality programs. However, shortages of many types of healthcare providers—and especially physicians—remain acute in rural Washington.

In my view, workforce development is a partnership between the public sector—the State of Washington and the Federal Government—and providers. In our State, this partnership has worked well, in large part, because a number of Federal programs—mainly operated through the Health Services and Resources Administration (HRSA)—provide us with tools that help us address our workforce needs.

For example, for years, the National Health Service Corps (NHSC) has been a critically important source for physicians in rural and underserved areas. A significant number of these physicians—two thirds after 1 year—have stayed in the State after completing their tour, according to a 2012 study.

Right now, there are 248 NHSC participants in 143 sites in Washington. The program provides some $5.8 million in fiscal year 2014 in loan forgiveness and scholarships to bring these physicians to underserved areas of our State.

The ACA extended funding for this program and the recently-enacted Medicare Access and CHIP Reauthorization Act of 2015 extended these funds further.

Our State also benefits from the Teaching Health Centers program authorized in the ACA, receiving $6.3 million over the 2014—2015 period. This program trains residents—about 28 per year—in community health centers and other non-hospital settings.

An overwhelming majority of residents practice permanently near where they did their residency, so investing in these programs is especially important.

HRSA has also provided nearly $6.4 million in funds to train nurses and allied health professionals.

These Federal workforce training programs complement the investments made by hospitals and the State of Washington. I strongly encourage the subcommittee to continue these invaluable investments.

The Future of Rural Health

The third bucket of challenges facing rural health focuses on long-term issues facing all of us in rural America. HRSA funds several programs important to the work of the Critical Access Hospitals (CAH) in our State.

The Rural Hospital Flexibility Grant Program, established in 1997 when the CAH designation was created, has provided invaluable resources to small rural and frontier communities as they strive to preserve access to medical care.

The State of Washington receives a little less than $600,000 a year from this program, which it is using to help CAHs improve the quality of the care they provide, better manage chronic diseases, improve emergency response to heart attacks and strokes, and strengthen their overall performance.

The Small Hospital Improvement Program has helped rural hospitals prepare for implementation of ICD–10 and implement quality improvement reporting.

These funds play a significant role in the operation of a CAH. They help ensure high quality care, but they also enable these cash-poor facilities to respond to the regulatory and administrative requirements they face.

I also want to highlight the collaborative work in the State of Washington that is funded by the Federal Office of Rural Health Policy for rural health network planning, development and outreach.

The first grant awardee is the Critical Access Hospital Network comprised of 12 CAHs and 20 rural health clinics. This network will receive $876,000 over 3 years to integrate primary care and behavioral health, and to improve chronic care delivery using health information technology. It will also work to develop a shared health information technology infrastructure link to a common dataset to reduce chronic disease.

For example, all primary care clinics are working on reduction of hypertension by measuring the percentage of patients able to manage their blood pressure and targeting quality improvements.

The second grant awardee, in which PMH is a participant, is the Washington Rural Health Collaborative made up of 13 public hospital district CAHs and 18 rural health clinics. The collaborative received $864,000 over 3 years to develop and implement a system to benchmark quality and financial indicators and to position the 13 CAHs for participation in accountable care organizations and value-based purchasing.

As an independent hospital, it is challenging to be ready to participate in new clinical and payment models. Collaboration is one key to successfully developing these new models. The Collaborative and the Network are two examples of effective collaboration.

Also important to highlight is the role that the State Office of Rural Health plays in facilitating these rural collaborative efforts. The office provides the infrastructure that helps local rural communities implement new models for CAHs.

The office also provides the communication and technical assistance link between the Federal Government and local communities. State Office of Rural Health funds are matched three times by the State, creating a unique Federal/State/local investment and partnership.

New Models for Rural Health Care

Additional work is also underway in our State to develop a new model for the most vulnerable CAHs. The Washington State Hospital Association (WSHA), a private nonprofit trade association of 99 hospitals, has identified 10 to 12 CAHs that could close their doors in the near future unless they receive payment flexibility and relief.

WSHA, the Washington State Department of Health, the Washington State Health Care Authority and several groups of providers are actively seeking to identify the appropriate model for ensuring that residents of these most vulnerable rural areas continue to have access to affordable healthcare services.

The Centers for Medicare and Medicaid Innovation has made an invaluable contribution to this effort—a $65 million award to transform healthcare delivery in the State of Washington. A small portion of these dollars will be used to develop a new payment method for these vulnerable CAHs.

The CAH model preserved access to hospital and clinic services in many rural and frontier communities, but it is not working in all situations. Changing utilization patterns—the shift from inpatient to outpatient and post-acute care—and low volumes of patients, especially commercially insured, have put financial strain on some CAHs.

A new payment model would not only change how we pay for healthcare, but should also adapt the current delivery system to better meet the unique needs of these communities. Thanks to the State of Washington's recent CMMI grant, we hope to develop such a model that can be tested starting in the next 12 to 18 months.

For a new model to succeed, we cannot be bound by the strictures of the past, but must look for new ways to create the flexible regulatory environment needed to design new options for rural healthcare. I strongly encourage the Federal Office of Rural Health Policy and CMS to work together to help us develop these new and innovative models.

Conclusion

As a CAH administrator, I'm very proud of the quality of the care we provide in Washington's small hospitals. We are working hard—in part with Federal funding—

to improve quality and patient safety even more. That means identifying quality indicators that reflect the care we actually provide and developing a value-based system that reflects the services available in our facilities.

The Federal Office of Rural Health Policy and the Washington Office of Rural Health have been invaluable partners in this journey. Federal funding has made a material difference in our ability to provide high quality care to people in our communities.

As a person who has worked almost her entire career in rural healthcare, I am dedicated to ensuring that the people who live in rural communities have access to the highest quality, affordable medical treatment.

I am optimistic that we will be able to achieve this goal. The programs we have discussed at this hearing go a long way toward getting us there, but much more remains to be done. I look forward to working with policymakers as we move forward.

Thank you for your attention and for this opportunity to speak to you today.

Senator BLUNT. Thank you, Ms. Petersen.

Mr. Stover.

STATEMENT OF GEORGE STOVER, CHIEF EXECUTIVE OFFICER, RICE COUNTY HOSPITAL DISTRICT #1

Mr. STOVER. Mr. Chairman and members of the committee, thank you for the opportunity to speak to you today. My name is George Stover, and I serve as the Chief Executive Officer of Hospital District #1 of Rice County in Lyons, Kansas. Lyons is a community in north central Kansas that has a population of 3,800. Our community hospital, which first opened in 1959, is a 25-bed critical access hospital that employees approximately 150 individuals.

Rural community hospitals have a long and distinguished commitment of providing care for all who seek it, 24/7, 365.

More than 36 percent of all Kansans live in rural areas, and depend on a local hospital serving their community. Rural hospitals face a unique set of challenges because of their remote geographic location, small size, scarce work force, physician shortages, higher percentage of Medicare and Medicaid patients, and constrained financial resources that limit access to capital. These challenges alone would make it difficult for many rural hospitals to survive.

However, one disturbing challenge that is becoming ever increasingly more prevalent is the added regulatory burdens that are being placed upon healthcare providers. More specifically, I would like to briefly touch upon the challenges related to the Medicare policy on direct supervision of outpatient therapeutic services and the 96-hour physician certification requirement.

In 2009, the Center for Medicare and Medicaid Services issued a new policy for direct supervision of outpatient therapeutic services that hospitals and physicians recognized as burdensome and unnecessary policy change. In essence, the new policy requires that a supervising physician be physically present in the department at all times when Medicare beneficiaries receive outpatient therapeutic services. As a result, many hospitals have found themselves at increased risk for unwarranted enforcement actions.

While the congressional action last year to delay enforcement was applauded by rural hospitals like mine, the protections afforded it under the legislation expired at the end of 2014. Rural hospitals are again at risk for exposure unless Congress takes action.

The 96-hour physician certification requirement relates to the Medicare conditions of participation on the length of stay for crit-

ical access hospitals. The current Medicare condition of participation requires critical access hospitals to provide acute in-patient care for a period that does not exceed, on an annual average basis, 96 hours per patient.

In contrast, the Medicare condition of payment for critical access hospitals requires a physician to certify that a beneficiary may reasonably be expected to be discharged within 96 hours after admission to the critical access hospital.

As a rural hospital administrator, the discrepancies between the conditions of participation and the conditions of payment have caused confusion and challenges.

Equally troubling, the President's fiscal year 2016 budget proposal calls for critical access hospitals' reimbursement to be reduced from 101 to 100 percent of allowable costs. This reduction, which would be on top of the 2 percent reduction associated with sequestration, would effectively eliminate any opportunity for a positive financial margin.

Further, the recent consideration by Congress on the trade promotion authority bill that extends sequestration cuts on Medicare providers potentially exacerbates our financial challenges. Toward that end, a recent analysis within our State showed that 69 percent of rural Kansas community hospitals had a negative Medicare margin. The average rural Medicare margin was a negative 9.3 percent.

As a result of this trend and the fact that many rural hospitals serve a higher percentage of Medicare beneficiaries, many rural community hospitals in Kansas must seek some form of direct tax support from their local communities.

In summary, it is critically important that our rural communities across the Nation are able to access quality healthcare services. Therefore, steps should be taken to minimize the regulatory burdens that are placed upon rural health care providers.

I strongly encourage this subcommittee to support solutions that address the aforementioned issues. Thank you again for the opportunity to appear before you, and I would be happy to stand for any questions. Thank you.

[The statement follows:]

PREPARED STATEMENT OF GEORGE STOVER

Mr. Chairman and Members of the Committee: thank you for the opportunity to speak to you today. My name is George Stover and I serve as the chief executive officer for the Hospital District #1 of Rice County in Lyons, Kansas. Lyons is a community in North Central Kansas that has a population of nearly 3,800. Our community hospital, which first opened in 1959, is a 25 bed critical access hospital that employs approximately 150 individuals.

Rural community hospitals have a long and distinguished commitment of providing care for all who seek it, 24/7/365. More than 36 percent of all Kansans live in rural areas and depend on the local hospital serving their community. Rural hospitals face a unique set of challenges because of their remote geographic location, small size, scarce workforce, physician shortages, higher percentage of Medicare and Medicaid patients, and constrained financial resources with limited access to capital. These challenges alone would make it difficult for many rural hospitals to survive. However, one disturbing challenge that is becoming ever-increasingly more prevalent is the added regulatory burdens that are being placed on healthcare providers. More specifically, I would like to briefly touch upon the challenges related to the Medicare policy on direct supervision of outpatient therapeutic services and the 96-hour physician certification requirement.

In 2009, the Centers for Medicare and Medicaid Services issued a new policy for "direct supervision" of outpatient therapeutic services that hospitals and physicians recognized as a burdensome and unnecessary policy change. In essence, the new policy requires that a supervising physician be physically present in the department at all times when Medicare beneficiaries receive outpatient therapeutic services. As a result, many hospitals have found themselves at increased risk for unwarranted enforcement actions. While the Congressional action last year to delay enforcement was applauded by rural hospitals like mine, the protections afforded under the legislation expired at the end of 2014. Rural hospitals are again at risk for exposure unless Congress takes further action.

The 96-hour physician certification requirement relates to the Medicare condition of participation on the length of stay for critical access hospitals. The current Medicare condition of participation requires critical access hospitals to provide acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient. In contrast, the Medicare condition of payment for critical access hospitals requires a physician to certify that a beneficiary may reasonably be expected to be discharged within 96 hours after admission to the critical access hospital. As a rural hospital administrator, the discrepancies between the conditions of participation and conditions of payment has caused confusion and challenges.

Equally troubling, the President's fiscal year 2016 budget proposal calls for critical access hospitals' reimbursement to be reduced from 101 to 100 percent of allowable costs. This reduction, which would be on top of the 2 percent reduction associated with sequestration, would effectively eliminate any opportunity for a positive financial margin. Further, the recent consideration by Congress on the Trade Promotion Authority bill that extends sequestration cuts on Medicare providers potentially exacerbates our financial challenges. Towards that end, a recent analysis within our State showed that 69 percent of rural Kansas community hospitals had negative Medicare margins. The average rural Medicare margin was −9.3 percent. As a result of this trend, and the fact that many rural hospitals serve a higher percentage of Medicare beneficiaries, many rural community hospitals in Kansas must seek some form of direct tax support from their local communities.

In summary, it is critically important that our rural communities across the Nation are able to access quality healthcare services. Therefore, steps should be taken to minimize the regulatory burdens that are placed on our rural healthcare providers. I strongly encourage this subcommittee to support solutions that address the aforementioned issues. Thank you again for the opportunity to appear before you. I would be happy to stand for any questions.

Senator BLUNT. Thank you, Mr. Stover.

I think I'll go last this time. So the order would be Senator Murray, Senator Cochran, and Senator Moran.

Senator Murray.

Senator MURRAY. Thank you very much, Mr. Chairman.

Thank you very much to all of our panelists. I really appreciate all of you participating today.

Ms. Petersen, I'm really excited to hear about the delivery system reform work underway in Washington State, and I'm really proud that our hospitals have been recognized as national leaders in increasing the quality and safety of care. I'm particularly excited about the recent grant from the Center for Medicare and Medicaid Innovation that you mentioned in your testimony to support the Healthier Washington Initiative efforts to improve care statewide that will reduce costs and stabilize some of our rural hospitals.

What have you found to be the most significant barriers to integrating care in the first year of this effort?

Ms. PETERSEN. At this point—and you're right, it is very exciting what is going on in the State of Washington—I would go back to that fragmented reimbursement system. Not only are the incentives different based on what line of service you're providing, but as my colleague mentioned about the RACs and the amount of time it takes to reimburse some of these systems, it's years out before we know what our true financial condition really is.

So I would call out that fragmented reimbursement system, but we also need current, really relevant data to move forward with when we talk about value-based purchasing and population health.

So I would say stability in reimbursement is one of the barriers, and the other is just a true, reliable database for rural residents.

Senator MURRAY. Okay. And talk to us about some of the specific reforms that we can expect to be seen implemented in the first year of this.

Ms. PETERSEN. Well, what I would expect to see is this continued movement toward value-based purchasing and defining quality. And, again, I think Washington State has done an excellent job of doing that. Led by the Washington State Hospital Association, all of the hospitals in Washington are participating in reporting their quality data. So the rurals are right in there.

I would expect that that's going to continue to happen. What I would like to see is more focus on what is relevant in rural communities. When we report into Hospital Compare, too frequently that grid of data has gaps for our rural facilities, because we're not measuring those things that are occurring and really contributing toward quality outcomes and reduced costs in rural hospitals.

Senator MURRAY. Such as?

Ms. PETERSEN. Our hospital-acquired conditions, our ability to reduce readmissions from our emergency department and our inpatients. One of the grants that you mentioned, the Community Paramedic Program, is actually hosted by my hospital, and it has been a tremendous success, taking our EMS resources out into the community to see people after they've been discharged, making sure that they're following their discharge instructions, getting their prescriptions filled, and that they have made that primary care follow-up. So those are some of the things I'd like.

Senator MURRAY. We've had a chance to talk that, but it's fascinating to me that just that human touch on somebody, making sure they take their medication or that they follow what was told to them when they left the hospital reduces costs in the long run.

Ms. PETERSEN. It does. And they're in their own home where they can think through their questions. We also get a look at the home and the environment they've been discharged into to make sure it's safe and appropriate. It's a great program.

Senator MURRAY. I'm really looking forward to more on that.

One last question. What more can CMS do to help rural communities make greater use of telemedicine?

Ms. PETERSEN. Well, telemedicine in the context we usually talk about is a direct link between the patient and a provider in a remote location, or a patient talking to someone at an academic medical center.

In our facility, we also use telemedicine to support our local providers. So they can have that consult discussion with somebody at the University of Washington or someone at Swedish.

CMS right now, I think Mr. Cavanaugh answered some questions about the metropolitan statistical area restrictions that we have. That's a very antiquated assumption, that if you increase telemedicine, you're going to increase costs.

In fact, you're going to take that very, very scarce work force that we have in rural America and you're going to be able to extend it.

It will be more efficient. And you'll create access in our communities.

Senator MURRAY. Okay. Very good. Thank you very much for being here and your testimony. I appreciate it.

Thank you, Mr. Chairman.

Senator BLUNT. Thank you.

Senator Cochran.

Senator COCHRAN. Thank you, Mr. Chairman.

Dr. Henderson, you mentioned in your testimony that the reimbursement parity issue was an important factor in the growth of services that are rendered through telehealth services. The diabetes pilot project you described are really remarkable and obviously highlight the potential for significant cost savings if they could be expanded into communities across the country.

What do you see as the programs that could be expanded? Are we talking about the diabetes pilot project? Is that a possibility to serve more communities?

Dr. HENDERSON. Yes. We can expand the diabetes program to other geographic regions, but we can also expand it to other chronic diseases. That program in particular is a remote patient monitoring program where we are helping day to day with patients in their home manage their disease and keep them healthy, and using the resources that are in that community more efficiently.

But from the telehealth perspective, it really is about connecting and coordinating all the care teams. It is not just a physician service. It is a nursing one. It is interpreters. It is case managers. It is patient navigators. Once you have this infrastructure and connectivity, you can connect any of those resources to bring what would only be in an academic medical center to a rural community.

Senator COCHRAN. Thank you for your leadership. We think we benefit from these experiences that you described for us today, and I hope we can help achieve those goals of expansion and improved access for less cost.

Dr. HENDERSON. Thank you.

Senator BLUNT. Senator Moran.

Senator MORAN. Mr. Chairman, again, thank you very much for conducting this hearing. And I appreciate our witnesses. Thank you for what you do in your communities to make certain that citizen patients are well cared for.

Let me start with the Kansan. Mr. Stover, welcome to our Nation's capital. Thank you for coming from Kansas to testify.

I want to go back to what I was trying to raise with the previous panel about actual cost base reimbursement. Can you give us an idea, even though presumably you receive 101 percent of cost, what percentage of your actual costs are covered by that reimbursement? You might start by telling us what percentage of your patients are Medicare and Medicaid? What is your payer mix? Is there public or taxpayer support for hospital? How do you make this work, even though presumably the image is that you're getting 101 percent of your cost?

Mr. STOVER. Thank you, Senator Moran.

Within Hospital District #1 in Rice County, our Medicare volume is about 63 percent, Medicaid volume of about 10 percent. We are

a taxing entity. We are able to appropriate tax funds from our district, which is about $900,000.

What is interesting with that number, in our fiscal year ending in 2014, we ended up having to write off nearly $800,000 to Medicare bad debt, so that essentially washes itself out.

When it comes to the cost base, you're absolutely right. Our reimbursement of 101 percent does not equate to our total cost of providing that healthcare within our facility. I don't know that number off the top of my head exactly, but I would say it's probably around the 75 to 80 percent margin, which covers our costs.

So we have to look toward our local tax base to make up that difference or otherwise start looking at reduction of services, which we do not want to do.

Senator MORAN. It used to be that hospitals would tell me that that mix, that 70-some percent Medicare-Medicaid, I suppose you do everything you can to cost-shift that to those who have private insurance, but are those opportunities as available now? Is it better to have a Medicare patient, a private pay patient, a Medicaid patient, as far as revenue? How do you compensate for less than actual reimbursement of costs? Where do you make up that money other than taxes? Can you do it with private pay?

Mr. STOVER. We work toward our uninsured, our private pay in their struggles. But, no, it doesn't come toward——

Senator MORAN. Let me ask the question this way, Mr. Stover. Are you pleased when a Blue Cross and Blue Shield-covered patient walks in your door? Does that mean this is a better deal than if it was Medicaid or Medicare?

Mr. STOVER. We look forward to the Blue Cross Blue Shield patient coming to our facility.

Senator MORAN. And the problem is that the percentage of those who come in the door is a small percentage?

Mr. STOVER. A very small percentage, yes, sir.

Senator MORAN. You mentioned uninsured and having to write off costs, and I'm not trying to portray this as partisan or the way this issue is looked at around here too often, but under the Affordable Care Act, a theory was that there would be more people insured. Has that proven to be true, in light of what you just said about hoping that the private insurance-covered patient walks in the door?

Mr. STOVER. We have seen a small increase of those individuals that were once uninsured; we are finding them to be enrolled in Medicaid. In our State-based MCO program that we have, we have seen a small increase in the marketplace of those that once did not have insurance but otherwise found it on the marketplace.

But when you look at the overall, that is a very small percentage of those individuals. They still find themselves uninsured.

Senator MORAN. Some hospital administrators have told me that even with additional insureds, that the co-payments and deductibles are higher. And, therefore, the bad debt expense has increased even with those who have insurance.

I think the way I described this is, somebody who had a $100 co-payment could come up with $100, but if it's a $5,000 deductible, they can't do that, so you end up writing off more even though there might, as you say, be a slight increase in insured?

Mr. STOVER. That is correct. We're finding that even though the co-pays in the past have been lower, we're finding that the co-pays now, those individuals are now on a payment plan. In turn, sometimes we are having to write those off.

Senator MORAN. Let me ask a broader question. Perhaps it's Dr. Henderson, but Ms. Petersen talked about telemedicine as well. I would just like to have the summary of the costs associated with telemedicine and how they are paid for. As I was listening to your testimony, I jotted down three things I think that the hospital would have to pay for, the equipment, I'm interested if you could just—I'm sure you've noted this in your testimony but I would like to get this in a short summary, so that I can understand it.

You have to figure out how to pay for the equipment. You have to figure out how to connect, and how that is paid for. And then finally, how does the provider get reimbursed for providing the service?

My question there is, when the University of Kansas Medical Center in Kansas City provides telehealth to the Rice County District #1 hospital, is there a reimbursement to the physician who is present in Kansas City at the major hospital? And is there any reimbursement that then comes to the hospital that's providing the service at the other end?

I don't know who is the person to answer that question.

Dr. HENDERSON. Your points are absolutely correct. There has to be purchase of equipment. There has to be connectivity. And you need to pay for the clinical or medical services that are delivered. So that's accurate.

How we're doing it in our State is that our center for telehealth is providing all of the equipment. So thanks to some of these Federal funding dollars, I'm able to deploy that, so that is not an upfront capital cost to them.

Senator MORAN. I know you're talking about Mississippi, but would that be true generally across the country, that there are grants available for the equipment?

Dr. HENDERSON. The majority of all of these programs have started off of grant money.

Senator MORAN. Thank you.

Dr. HENDERSON. In our State, we're able to pay the provider who delivers the service, so the telehealth physician or nurse practitioner, they are paid, their professional fee, through reimbursement——

Senator MORAN. Here you're talking about the provider out in the rural setting?

Dr. HENDERSON. I'm talking about the other side.

Senator MORAN. All right.

Dr. HENDERSON. So where the patient is, there can be a facility fee billed, and that can be reimbursed as well. And that helps offset their cost for facilitating that interaction.

Typically, it's not a provider to provider, because both providers cannot be paid for the same service. If you have a generalist with a specialist and they both do an exam, then they both can bill.

Senator MORAN. So you have a general practice physician at Rice County District #1 and specialist at the K.U. Medical Center, both of them can bill?

Dr. HENDERSON. If they are doing different services, yes.

Senator MORAN. So there is no disincentive to a provider to make this happen?

Dr. HENDERSON. As long as you're in a State that allows for parity reimbursement.

Senator MORAN. All right, I'll have to figure that out.

Finally, let me ask you to clarify for me, when we talk about that reimbursement, does it matter who is providing the insurance, Medicaid versus Medicare versus private insurance? Is your answer the same in all three settings?

Dr. HENDERSON. It's not. It depends on your State and what the legislation allows for. Then Medicare has geographical restrictions as well that we've heard.

But in our State, all public and private payers in Mississippi, Medicaid included, have a parity reimbursement for telehealth, same as in person.

Senator MORAN. Chairman Blunt, do you want me to stop or ask one more?

Senator BLUNT. You can ask one more.

Senator MORAN. To Missouri, maybe this will make Senator Blunt happy, Mr. Wolters, how does this work in Missouri, as far as Medicare versus Medicaid versus private pay for telehealth? Or, Mr. Stover, how does it work in our State?

Mr. WOLTERS. I can answer that for Missouri. We have invested heavily in telehealth in Bolivar using grant funds for the equipment.

The problem with Medicare, the geographic restrictions are such that we have a network of 12 rural health clinics that we operate. They are rural, for the purposes of being rural health clinics under the Medicare health program. Four of those clinics are considered urban for telehealth purposes. So if the patient is in that rural health clinic in an urban rural health clinic, then they are not covered by Medicare and cannot access telehealth services.

We also have six long-term care facilities that we operate. Two of those six are in urban locations. So there are times when the patient may have an event going on at the long-term care facility, and we would like to have a doctor see that patient, but if it is in an urban facility, they cannot use telehealth under the Medicare program.

So essentially would have to transport the patient by ambulance over to the ER to access care that probably could've been provided by telehealth except for the fact that Medicare defines that as an urban facility.

Senator MORAN. From a reimbursement of cost to the Medicare trust fund, that doesn't make any sense, right?

Mr. WOLTERS. No, sir.

Senator MORAN. Right.

Mr. Chairman, thank you.

Senator BLUNT. You used all of your time and all of my time.

It was astounding.

Senator MORAN. It was Missouri and Kansas cooperating.

Senator BLUNT. Exactly.

Mr. Stover, you mentioned you had a health tax that provided about $900,000 a year, but you lost $800,000 in Medicare bad debt? Is that what you said, Medicare bad debt?

Mr. STOVER. Yes, sir.

Senator BLUNT. Everybody on the panel understands that, but I don't. How would you have Medicare bad debt?

Mr. STOVER. Well, it is the bad debt that we recognize on our Medicare cost report.

Senator BLUNT. Okay, it's not bad debt that the Medicare system owes you.

Mr. STOVER. That's correct.

Senator BLUNT. In your reporting to Medicare, you're reporting that you have $800,000 of bad debt.

Mr. STOVER. That's correct.

Senator BLUNT. All right. I see. That's helpful to me to understand that.

Mr. Wolters, I saw that there's an AP story out today and a KWMU story out today on a Harvard study that indicates of the 195 hospital closures nationwide, that they really had very little impact on patients unless you were in rural settings. That headline says in rural Missouri, but reading the article, it is clear that it is a Missouri story, but it means rural settings anywhere.

You had close to CMS in Bolivar, the hospital at Osceola closed. Do you want to talk about what you did, what your system did there to try to alleviate some of that loss of service?

Mr. WOLTERS. Thank you, Senator.

The hospital in Osceola, about 35 miles north of Bolivar, closed November 1. Of course, that represented a loss to that community, no more inpatient beds, no more emergency room, and the loss of quite a few healthcare jobs.

We did step forward. We have taken over the operation of their ambulance service. We've taken over the operation of their rural health clinic. In fact, we converted that rural health clinic into a walk-in clinic that is open 7 days a week, 12 hours a day, so they can provide access to the patients in the area.

We've also taken over the operation of the retail pharmacy that they had. That's the only pharmacy in town. And we have added rehabilitation services for physical and occupational and speech therapy services in that community.

So we have tried to provide outpatient care and provide the ambulance care to transport them to whatever hospital is appropriate when a patient has the need for emergency care. So we have tried to help alleviate the loss to that community.

Again, that is certainly a severe loss to Osceola.

Senator BLUNT. Yes, it is. I think their payer mix, looking at that hospital, it's almost exactly the same payer mix described, Mr. Stover, and maybe, Ms. Petersen, about the same payer mix you have.

Ms. PETERSEN. My system is about 65 percent Medicare, Medicaid.

Senator BLUNT. And then how much uninsured?

Ms. PETERSEN. About 7 percent, at this point.

Senator BLUNT. So you have Medicare and Medicaid at 65 percent, 7 percent uninsured, and the rest of your patients have some kind of coverage?

Ms. PETERSEN. Some sort of commercial coverage, correct.

Senator BLUNT. On RAC audits, did you mention, Mr. Wolters, you had 500 claims currently?

Mr. WOLTERS. They are still sitting at the ALJ level in the backlog at the hearings center for the ALJs. We have had about 1,000 denials overall over the past 4 or 5 years. We have appealed about 85 percent of those denials. Of those that have been heard, at any level of appeal, we have been successful about 90 percent of the time in overturning the denial. But the vast majority of the appeals are still sitting at the ALJ level and probably will be for another couple years.

Senator BLUNT. And has CMS suspended RAC audits because there is no appeal process right now? Or are you continuing to have those audits?

Mr. WOLTERS. At this point, CMS is reworking the contracts for the RACs, so they essentially suspended activity while they are renewing the contracts. CMS has said they are going to make some changes in the RAC program. It appears to us that the changes may not go far enough in terms of trying to correct what is wrong with the RAC program, the overly aggressive incentives of recovery auditors to deny claims and take their percentage fees, regardless of the fact that most of those get overturned. There's really no penalty to the RAC auditor at this point.

So they can deny as many as they want. Sometimes they pay the money back and sometimes they keep it, but they keep it for several years while the appeal is in process.

Senator BLUNT. So of the 500 claims and $3.5 million, you had to return that money?

Mr. WOLTERS. Right. The money is gone right now. We are just waiting for it to hopefully come back somewhere down the road.

Senator BLUNT. And if your past history was right, the odds are somewhere in the neighborhood of 90 percent that you will get that money back. But of course, you don't know when you will get it back, and the use of the money is gone, and you can't plan to get it back?

Mr. WOLTERS. Yes, sir. That is correct.

Senator BLUNT. Ms. Petersen, what is your RAC audit history? Or your views on how that system is working?

Ms. PETERSEN. Well, I couldn't agree more that the incentives don't align with a legitimate, helpful audit process. Coding and determining whether someone is an observation patient or an inpatient is very complex. We do welcome the ability to review those and go through a legitimate audit process.

The problem is that these are essentially bounty paid claims, so they get 9 percent to 12 percent, or whatever the percentage is, of any claims that they overturn or that they deny. They also have the ability to look at the entire record and second-guess the physician who saw the patient at 2 o'clock in the morning in the ER. So they are looking at a closed record of a 4-day length of stay, that if the ER physician had the information that they had from the patient at that time. I think the other thing is that there is a very, very long window that they can go back and deny those claims and review those claims. That also needs to be shortened up.

Senator BLUNT. Mr. Stover.

Mr. STOVER. Within our facility, being a critical access hospital, we are maybe the outlier in that we have not had any particular RAC issues, as such. We have had minor ones, but we have not been—I guess, we are just the outlier.

But within Kansas, we have a number of my colleagues and facilities out there that are faced with the continuance of having to fight for or prove through their appeal process.

Senator BLUNT. Is this process different for critical access hospitals?

Mr. STOVER. I am not aware. Individually, I'm not aware.

Senator BLUNT. So you happen to be a critical access hospital, but you don't know that's why your experience is different?

Mr. STOVER. That would be correct. I don't know if our expenses are different.

Senator BLUNT. I'm using the Moran standard, so I get another 3 minutes here.

Mr. WOLTERS. I would say one of the big areas that recovery auditors are looking at is the decision to admit or not to admit a patient. So one difference with a critical access hospital is inpatient or outpatient, it is still cost reimbursed. There is less of an impact on Medicare reimbursement there for a critical access hospital because they get paid for the care, whether it is called inpatient or outpatient.

For a PPS hospital like CMH or Lake Regional, we get paid a higher payment for an inpatient admission than for an observation patient, so there's a significant difference in the level of payment.

Senator BLUNT. One other major item to audit is whether you should have put that person in the hospital or not?

Mr. WOLTERS. Exactly. They are not questioning the care we provide. They acknowledge the patient needed to be there. They are just saying it should not have been an inpatient. It should've been an observation patient. And that dramatically changes the level of reimbursement we get for that patient.

So that is what they're doing. That is why most of the activity is on the PPS side, although they are looking at critical access claims in certain areas.

Senator BLUNT. I've also been told, on the hospital wage index, that rural hospitals can constantly fall more and more behind compared to counterparts in other places.

Would you think that would be an accurate statement, Mr. Wolters?

Mr. WOLTERS. Yes, it is, because the data that CMS used to determine the wage index is usually several years old, so what happens is that that wage data goes down, you're paid less, and, therefore, you have less to spend on salaries.

It becomes kind of a cycle where you end up paying less to your staff. You don't give the pay increases that maybe an urban hospital would give. So you constantly gradually fall behind urban areas. So that does become a problem in rural areas.

Senator BLUNT. Similar are observations on wage index, from Ms. Petersen or Mr. Stover?

Ms. PETERSEN. The wage index, relative to critical access hospital reimbursement, is not as significant as in a PPS setting. However, the idea that physicians and specially trained nurses and

phlebotomists and technicians can be recruited to rural areas for less than they would earn in the urban areas is simply not true. We compete on a national level for these very, very scarce resources.

Senator BLUNT. The same observation, Mr. Stover?

Mr. STOVER. Yes, Mr. Chairman. I would agree with my colleague, Ms. Petersen.

Senator BLUNT. Dr. Henderson, my last question would be, on telemedicine, do you have behavioral health also?

Dr. HENDERSON. We do, yes.

Senator BLUNT. Are you being reimbursed for behavioral health in the same way you would be for all other health items?

Dr. HENDERSON. We are.

Senator BLUNT. Your goal is to recapture all costs?

Dr. HENDERSON. Correct. And to integrate behavioral health into medical clinics as well.

Senator BLUNT. Do you have any studies yet that would indicate how much better people do with their other health problems if you're dealing with their behavioral health problems at the same time?

Dr. HENDERSON. It's interesting. In our diabetes program, a component of our program is around medical adherence and lifestyle and behavior changes, which needs a strong mental health component as well for behavior change. So we're incorporating into that. We're not through with that study yet to be able to publish it.

But we're offering now mental health services even on college campuses and in schools, so it is one that will continue to grow. And it is probably one of our biggest demands right now.

Senator BLUNT. My personal belief that, certainly, societally, if you deal with mental health like it's every other health issue, whatever you spend comes back many, many times. But my personal belief is, even in the healthcare context, that you deal with every other health issue in a more effective way if you deal with behavioral health like it's a health issue rather than you've got lesser reimbursement, less of a commitment, whatever. I hope we can get there. I'm glad that you're getting there on your telemedicine program.

Any questions, Senator Murray?

Senator Cochran.

Senator COCHRAN. No, thanks, Mr. Chairman.

Senator BLUNT. Senator Moran.

Senator MORAN. You went a minute longer than I did.

Senator BLUNT. Would you like a minute?

Senator MORAN. No, Mr. Chairman. Thank you, though.

Senator BLUNT. Let's properly close out here.

ADDITIONAL COMMITTEE QUESTIONS

We'll leave the record open for a week for questions to be submitted.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

TELEHEALTH

Question. What are some of the barriers that telehealth programs have in expanding services and what is HRSA doing to alleviate these issues?

Answer. Data from the Federal Communications Commission (FCC) shows that some rural areas continue to lag behind urban population centers in access to affordable broadband, which can impede rural economic development and create challenges for rural communities seeking to leverage telehealth technology and implement electronic health records. While both the FCC and the USDA's Rural Utilities Service offer programs designed to increase access to broadband in rural areas, the FCC's Healthcare Connect Fund is specifically designed as a means to increase efficiency of care and build regional and statewide networks of providers engaged in telemedicine and health information exchange. FORHP works with the relevant agencies to make rural healthcare providers aware of these programs and how to use them.

In addition, the Federal Office of Rural Health Policy funds the Licensure Portability Grant Program, a competitive grant program that provides support for State professional licensing boards to carry out programs under which licensing boards of various States cooperate to develop and implement policies to reduce statutory and regulatory barriers to telemedicine across multi-jurisdictional areas. There are two grantees for this program: the Federation of State Medical Boards (FSMB) and Association of State and Provincial Psychology Boards (ASPPB).

Through FSMB, there are currently 22 medical boards that are using the Uniform Application, and 3 other medical boards are actively engaged to develop a State-specific addendum. Since its inception in 2006, 40,400 physicians have successfully submitted their application for licensure utilizing the Uniform Application, with more than 19,000 since 2012.

Through the ASPPB, more than 230 psychologists have submitted their applications via the Psychology Licensure Universal System, which began in 2012.

FSMB has proposed an Interstate Medical Licensure Compact, which would create a new pathway to expedite the licensing of physicians seeking to practice medicine in multiple States. The Compact would make it easier for physicians to obtain licenses to practice in multiple States and would strengthen public protection because it would help States share investigative and disciplinary information that they cannot share now.

HRSA additionally funds 12 regional Telehealth Resource Centers that deliver expert advice and guidance on using health technology and broadband to bridge geographic barriers. Two additional National TeleHealth Resource Centers provide policy, payment, and broad licensure research and technology assessments for health programs to consult with nationally.

Question. Many States are wrestling with what constitutes a "patient-provider relationship" when telehealth medicine is involved and these rules vary greatly from State-to-State. What is HRSA doing to help patients, providers, and States balance the convenience and access of telehealth options with the importance of engaging patients in a dialogue about their health with a physician who can manage their ongoing needs?

Answer. Telehealth is an important tool that can enhance healthcare delivery. HRSA's Telehealth Network Grant program has supported projects that emphasize providing these services within a larger coordinated system of care. While we recognize the importance of the patient-provider relationship, the issue is not regulated at the Federal level nor is it specified in our grant programs as it is most often regulated at the State level.

FSMB has proposed an Interstate Medical Licensure Compact, which would create a new pathway to expedite the licensing of physicians seeking to practice medicine in multiple States. The Compact would make it easier for physicians to obtain licenses to practice in multiple States and would strengthen public protection because it would help States share investigative and disciplinary information that they cannot share now.

Question. The Office of Rural Health administers several grant programs to provide funding for projects that demonstrate telehealth networks and improve healthcare services for medically underserved populations. How can HRSA adequately expand this program to ensure patients in underserved communities receive access to specialty care?

Answer. The authorization for the Telehealth Network Grant program requires HRSA to focus funding on projects that serve patients in rural and underserved areas. In fiscal year 2015, HRSA will fund a new Telehealth Research Center to bet-

ter understand key telehealth policy issues, which may include issues with specialty care, and also assess those telehealth applications for their clinical impact on the patients served. The purpose of this Research Center is to increase the amount of publically available, high quality, impartial, clinically-informed and policy relevant telehealth related research. This effort builds on a program HRSA began in fiscal year 2014 to support telehealth networks that can expand the evidence base for how telehealth services can enhance healthcare outcomes. HRSA will also soon release a Funding Opportunity Announcement for a telehealth program that focuses on children living in high poverty rural areas. The purpose of the Rural Child Poverty Telehealth Network Grant Program is to demonstrate how telehealth networks can expand access to, coordinate and improve the quality of healthcare services for children living in impoverished rural areas and in particular how such networks can be enhanced through the integration of social and human service organizations. HRSA will award up to three pilot grants for a total annual investment of $975,000 in fiscal year 2015 and $2.9 million over 3 years. Furthermore, the Federal Office of Rural Health Policy supports Telehealth Resource Centers, which are centers of telehealth excellence that provide technical assistance to rural communities, healthcare organizations, healthcare networks, and healthcare providers in the implementation of cost effective telehealth programs to serve rural and medically underserved areas and populations. The Heartland Telehealth Resource Center serves communities in Missouri, Kansas and Oklahoma.

Question. One of the biggest challenges to access of telehealth is CMS' level of reimbursement. What is CMS doing currently on this issue?

Answer. CMS pays for telehealth as directed by the statute. Section 1834(m)(2)(A) set the payment amount for physician or practitioner services furnished via telehealth equal to the payment amount for a face-to-face service. Section 1834(m)(2)(B) set the facility fee for the originating site, i.e., the site where the beneficiary is located, at $20 for the period October 1, 2001–December 31, 2002, updated by the Medicare Economic Index (MEI) in subsequent years. For CY 2015, the facility fee is $24.83.

OFFICE OF RURAL HEALTH POLICY

Question. The Department requested a $4.1 billion increase; however the Office of Rural Health account was reduced. Nearly 20 percent of Americans live in rural communities. Why is the Administration not prioritizing funding for the Office of Rural Health?

Answer. Rural health is an Administration priority in challenging financial times requiring difficult budgetary decisions. The Budget requests $128 million for the Federal Office of Rural Health Policy. The President's Budget includes a $25 million request to support the Rural Hospital Flexibility Grant (Flex) program, which works with Critical Access Hospitals (CAH), which are the smallest rural hospitals in the country and also tend to be geographically isolated. The Flex program supports quality improvement and performance improvement activities for CAHs. The Administration's request also fully funds the Rural Health Outreach program, which provides direct funding to rural communities for projects that improve access to and the coordination of care in rural communities. The Budget does not request funding for the Small Hospital Improvement Program, which provides small grants to hospitals with 50 beds or less, as it has become largely duplicative of other programs and resources, such as the Medicare Rural Hospital Flexibility and Rural Health Outreach grant programs. It also does not fund the Rural Access to Emergency Devices (AED) program. For rural communities seeking support for the placement of AEDs and training rural residents in their use this activity can be funded through the Rural Health Outreach program.

HRSA support for rural health programs is much broader than the Federal Office of Rural Health Policy programs. HRSA supports nearly 1,300 health centers operating approximately 9,000 health center service sites across the country, and approximately 50 percent of them serve rural communities. Moreover, about 44 percent of the National Health Service Corps field strength works in rural communities. In fiscal year 2014, HRSA programs, in total, provided approximately $1.3 billion in grant funding to rural communities.[1]

[1] According to data pulled from the Tracking Accountability in Government Grants System (TAGGS) on February 24, 2015, HHS awarded 7,394 rural awards totaling $1,275,660,814 in fiscal year 2014.

CRITICAL ACCESS HOSPITALS (CAHS)

Question. How did the CMS come up with the 10-mile limit in the President's budget request?

Answer. Limiting Critical Access Hospital designation to hospitals located within ten miles of the nearest hospital will ensure that only hospitals whose communities depend upon them for emergency and basic inpatient care will be designated as Critical Access Hospitals and receive reasonable cost-based reimbursement.

Question. Congress provided Critical Access Hospitals 101 percent of reasonable costs because other payment systems were designed for larger facilities, not small, low volume rural hospitals. How does CMS expect Critical Access Hospitals to survive on CMS' prospective payment system?

Answer. CMS conducted an analysis on the impact of this proposal on access to services in rural communities. Our analysis estimated that a maximum of 47 CAHs, out of a total of 1,339 certified CAHs, might be affected by this proposal. Moreover, facilities losing their CAH designation would not necessarily close. Instead, it is anticipated that many of these CAHs would continue to participate in Medicare as hospitals paid under the applicable prospective payment system, and would continue to provide hospital services to their communities without reliance on CAH designation. Hospitals that transitioned from their CAH status would be eligible for the Hospital Value-based Purchasing Program, which provides financial incentives for high quality of care and improvement in quality.

In the event that some of the potentially affected CAHs were to close, CMS analysis found that there likely is sufficient capacity in nearby facilities to provide the services any closed CAH had previously provided. CMS conducted an analysis of recent Medicare and cost report data for the potentially affected CAHs, as well as for the hospitals located within 10 miles of these CAHs. Overall, the data suggests that there would be no significant issues related to access to inpatient acute care services or skilled nursing services for the communities currently being served by the potentially affected CAHs should the CAH cease to provide services rather than convert its Medicare agreement to participate as a hospital.

Question. What is CMS currently doing to help ensure rural hospitals can remain open and provide quality healthcare to rural communities?

Answer. CMS administers a number of programs that seek to expand access to services in rural areas. Medicare's telehealth benefit allows beneficiaries to receive certain services from physicians located outside their community. Rural Health Clinics, help to provide access to primary care services in rural areas while Critical Access Hospitals provide access to inpatient and outpatient hospital care where care would otherwise be unavailable.

Last year, CMS finalized a rule that included reforms to Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and other healthcare providers, which will save nearly $660 million annually, and $3.2 billion over 5 years. This rule specifically outlined ways to reduce burdens on rural healthcare providers. For example, a key provision reduces the burden on very small Critical Access Hospitals, as well as Rural Health Clinics and federally Qualified Health Centers, by eliminating the requirement that a physician be held to a prescriptive schedule for being onsite. This provision seeks to address the geographic barriers and remoteness of many rural facilities, and recognizes telehealth improvements and expansions that allow physicians to provide many types of care at lower costs, while maintaining high-quality care.

There are other programs in HHS that are also available to help rural hospitals within the Federal Office of Rural Health Policy. The Medicare Rural Hospital Flexibility Grant program provides $25 million to support quality improvement and performance improvement activities in Critical Access Hospitals. This program's targeted technical assistance can help improve financial operations for these hospitals. Enhancing quality in CAHs can also help retain local patients and enhance patient volume. Rural hospitals can also apply for funding through the Rural Health Outreach grants to expand services, address workforce challenges and focus on chronic disease management and quality improvement. HRSA also supports the Rural Hospital Transition Technical Assistance contract which works with small rural hospitals in persistent poverty counties to assess operational performance and assist with adapting to a changing healthcare environment.

CMS REGULATIONS

Question. How does CMS take into account the impact of regulations on rural healthcare providers when proposing new regulations?

Answer. CMS analyzes the impact of regulations on all stakeholders—including rural health providers—before they are released. Given their importance to rural

communities, CMS has recently taken specific steps to work with stakeholders to reduce regulatory burden on rural health providers. Last year, CMS finalized a rule that included reforms to Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and other healthcare providers, which will save nearly $660 million annually, and $3.2 billion over 5 years. This rule specifically outlined ways to reduce burdens on rural healthcare providers. For example, a key provision reduces the burden on very small Critical Access Hospitals, as well as Rural Health Clinics and federally Qualified Health Centers, by eliminating the requirement that a physician be held to a prescriptive schedule for being onsite. This provision seeks to address the geographic barriers and remoteness of many rural facilities, and recognizes telehealth improvements and expansions that allow physicians to provide many types of care at lower costs, while maintaining high-quality care.

CMS also operates the Rural Health Open Door Forum (ODF), which provides an opportunity for stakeholder input on any issue that affects healthcare in rural settings. We cover topics such as Rural Health Clinic, Critical Access Hospital, and federally Qualified Health Center issues, among others. For example, CMS recently had a call devoted exclusively to Veterans Affairs issues and had an expert from VA to assist rural providers with billing for services provided to veterans. Topics that frequently arise in this forum often deal with payment policies, claims processing and billing for services, cost report clarifications, classifications for & qualifications of rural provider types, and the many special provisions of law designed specifically to improve rural healthcare. Timely announcements and clarifications regarding important rulemaking, quality program initiatives, and other related areas are also included in the Forums.

Question. How does CMS work with HRSA's Office of Rural Health in ensuring impacts to rural providers are considered?

Answer. CMS has rural health coordinators at each of our Regional Offices, who meet monthly with participation from CMS central office staff and the Health Resources and Services Administration (HRSA) to discuss emerging issues. In addition, staff from the Federal Office of Rural Health Policy (FORHP) take part in the review of all proposed regulations with a specific charge to analyze the impact on small rural hospitals and other providers. CMS and FORHP staff also meet regularly through the year to discuss the impact of current regulations and seek opportunities to reduce the regulatory and administrative burden on small, rural providers.

RURAL MEDICAL WORKFORCE

Question. CMS' Graduate Medical Education program could be a significant mechanism to reshape and modernize the healthcare workforce depending on current need, but this has not happened. CMS' current program focuses heavily on teaching hospitals and medical specialties. This reduces the opportunity for small rural hospitals to participate in the program and reduces the pool of primary care doctors. How can CMS allow for some flexibility under the Graduate Medical Education program and help rural hospitals attract and retain potential doctors?

Answer. CMS is committed to bolstering the Nation's health workforce and to improve the delivery of healthcare across the country. The President's fiscal year 2016 budget proposes a four part $14.2 billion investment beginning in fiscal year 2016. The proposals include:

—*Providing Targeted Support for Graduate Medical Education*.—The Budget proposes to establish a HRSA-administered competitive grant program to support medical residency positions that advance key health workforce goals. A total of $5.25 billion in mandatory funding, to be transferred from the General Fund, is requested for this program for fiscal years 2016—2025. This program will support an estimated 13,000 three-year medical residencies between fiscal years 2016 and 2025. In addition to traditional teaching hospitals, these grants will support children's teaching hospitals and teaching health centers. Grants will be awarded consistent with major HHS workforce goals. These goals include:
  —Training more physicians in primary care and understaffed specialties;
  —Encouraging physicians to practice in rural/underserved areas; and
  —Encouraging training in key competencies necessary for delivery system reform, such as team-based care and electronic health records.

—*Investing in the National Health Service Corps*.—The Budget new investments in the National Health Service Corps. The National Health Service Corps is one of HHS' most effective programs in addressing the mal-distribution of primary care providers. An increase in the Corps field strength will allow HHS to send these providers to high need areas across the country.

Question. Currently, CMS does not provide indirect costs for residents' training at hospitals such as Critical Access Hospitals, Sole Community Hospitals, or Medicare Dependent Hospitals. This discourages participation in the Graduate Medical Education program at rural facilities. Please explain the thought process behind this decision.

Answer. The law, at Section 1886(d)(5)(B) of the Act, provides an additional Indirect Medical Education (IME) payment to hospitals paid under section 1886(d) that have residents in an approved graduate medical education (GME) program for a Medicare discharge to reflect the higher patient care costs of teaching hospitals relative to non-teaching hospitals. A rural hospital may choose to be designated as a CAH, SCH, or an MDH, as applicable, in turn for Medicare payments that are more favorable than under the traditional IPPS. These hospitals are paid for the indirect costs of medical education, but in a manner somewhat different from traditional IPPS hospitals. Should these rural hospitals determine that it would be more financially beneficial for them to receive IME payments in the same manner as regular IPPS hospitals, they may choose not to be designated as a CAH, SCH, or MDH.

Sole Community Hospitals (SCHs) are paid based on their hospital-specific rate from specified base years, or the IPPS Federal rate, whichever yields the greatest aggregate payment for the hospital's cost reporting period. An MDH receives the higher of the Federal rate or the Federal rate payment plus 75 percent of the amount by which the Federal rate payment is exceeded by its hospital-specific rate payments.

SCHs and MDHs, unlike regular IPPS hospitals, have the opportunity to receive the "higher-of" two aggregate payments—one that is either based, in whole for SCHs or in part for MDHs, on their HSRs, or one that is based on the Federal rate. An MDH that is a teaching hospital does, in fact, receive IME Part A add-on payments since payment to an MDH, whether in whole or in part, is always based on the Federal rate.

An SCH that is paid based on its HSR does not receive a separate IPPS add-on for Part A IME because, generally, the HSR already reflects the additional costs that a teaching hospital incurs for its Medicare Part A patients. However, it should be noted that MDHs and SCHs may receive IME add-on payments for each Medicare Part C patient discharge, regardless of whether they are paid on the HSR or Federal rate.

Under the law, Critical Access Hospitals are not IPPS hospitals and are not paid under 1886(d) which would preclude any IPPS IME add-on payments. However, since CAHs are paid based on 101 percent of cost, any higher indirect costs they incur for graduate medical education training would already be captured in their reasonable cost payments.

COMMUNITY HEALTH CENTERS

Question. Now that Congress has appropriated mandatory funding for 2 more years to avoid the last fiscal cliff, how will HRSA manage the program to ensure we are not in the same situation in 2017?

Answer. In recent years the Health Center Program has relied on both mandatory and discretionary funding. The Administration looks forward to working with the Congress on this important issue to ensure the Health Center Program can continue the provision of comprehensive primary healthcare services to the vulnerable populations across the country into the future.

Question. What is HRSA doing to address workforce shortages in rural areas and Community Health Centers?

Answer. HRSA has a number of efforts underway to address workforce challenges in rural areas. On the training side, HRSA's Bureau of Health Workforce supports programs that train physicians, nurses, physician assistants, psychologists, dentists and other key healthcare professionals to work in underserved areas. In 2014, approximately 180,000 students, residents, fellows and faculty from rural areas were supported by HRSA training grants. Across these training programs, HRSA emphasizes the importance for students to get exposure to rural training sites, and in fiscal year 2014, HRSA training programs included more than 11,000 training sites in rural communities.

The Federal Office of Rural Health Policy supports Rural Training Tracks (RTTs) for family medicine residency programs. There are currently 34 RTT family medicine residency programs. Through our continued support of the Rural Recruitment and Retention Network, we partnered with the States to place more than 1,700 clinicians in rural communities across the country in 2014.

In fiscal year 2015, HRSA has awarded 164 New Access Point grants, of which 74, totaling $45.6 million, will create new health center sites in rural communities.

Further, approximately 50 percent of National Health Service Corps clinicians serve in health centers around the country, and nearly half of all current Corps providers work in rural communities.

Question. How effective is the National Health Service Corps in placing clinicians in rural facilities and how many of those actually continue to serve in rural settings once their term of commitment ends?

Answer. The National Health Service Corps (NHSC) has demonstrated a high degree of effectiveness in placing clinicians in rural facilities. As of September 30, 2014, more than 9,200 primary care medical, dental, and mental and behavioral health practitioners provide services nationwide at NHSC-approved sites in rural, urban, and frontier areas. Nearly half (44 percent) of those NHSC clinicians serve rural sites.

NHSC continues to monitor the retention rates of NHSC scholars and loan repayors in service to the underserved beyond the fulfillment of their service commitment. NHSC defines retained clinicians as those who provide care in a designated health professional shortage area (HPSA) after their service obligation ends. The fiscal year 2014 Participant Satisfaction Survey found that 86 percent of NHSC providers, who completed their NHSC service commitment in the past 2 years, have continued to work in a HPSA. The short-term retention rate of 86 percent demonstrates a 1 percent increase from the fiscal year 2013 rate of 85 percent.

Further, among NHSC clinicians who completed their service commitments in rural settings, according to the fiscal year 2014 NHSC Participant Satisfaction Survey, 95 percent of these respondents have continued to work in HPSAs in rural areas.

WAGE INDEX

Question. When determining prospective payments to hospitals, CMS adjusts reimbursements amounts to account for differences in areas. Urban hospitals must be reimbursed for wages paid to doctors and staff at least as much as rural hospitals. This issue was further complicated by a provision of the Affordable Care Act that requires the Medicare reimbursements to come from a national pool of money, instead of the previous State allocation. While typically rural hospitals have lower wages than urban hospitals—hospitals in Massachusetts and California that are designated as rural hospitals due to their remote location, have particularly high reimbursement rates due to the high cost of living. However, this has led to other hospitals in those States receiving extremely high reimbursements at the cost to other hospitals in States like Missouri. Missouri, for example, has lost over $80 million in reimbursements. How much in Medicare reimbursements have been lost in other rural States such as Alabama, Kansas, and North Carolina since this provision was enacted?

Answer. Beginning with the fiscal year 2011 wage index, the Affordable Care Act (Public Law 111–148) required CMS to apply a national rural floor budget neutrality factor instead of a State specific factor to the wage index of every hospital paid under the IPPS. Below we provide our general estimate of reductions in Medicare expenditures due to national rural floor budget neutrality for fiscal year 2012–2016 for the requested States as a result of this statutory requirement.

State	Estimated Reduction in Expenditures Due to National Rural Floor Budget Neutrality (2012–2016 *) ($ in millions)
Alabama	(39)
Arkansas	(24)
Missouri	(52)
North Carolina	(75)

*Fiscal year 2011 data is not readily available.

Question. What constitutes a rural hospital for purposes of the rural floor reimbursement?

Answer. CMS calculates each State's rural floor wage index value by choosing the highest value from the following groups' wage data: (1) hospitals located in a State's geographically rural areas, or (2) hospitals that are geographically rural, but reclassified to an urban area within the State, or (3) hospitals that are geographically urban, but reclassified to an area that is rural within the State.

Question. Is CMS pursuing any rule-making actions to fix this problem?

Answer. Because the ACA requires that rural floor budget neutrality be calculated at the national level, CMS does not have the authority to calculate budget neutrality in a different manner.

QUESTIONS SUBMITTED BY SENATOR JERRY MORAN

Question. A significant regulatory burden I hear about when visiting hospitals in Kansas are problems with Medicare RAC audits. Hospital administrators tell me they support the idea of efforts to eliminate fraud, and even honest mistakes that occur with the complex billing that comes along with Medicare. However, that isn't what they are seeing get caught up in the RAC process. They tell me about extensive document requests that take not only administrators' time, but also the time of doctors (which are in short supply in rural America due to medical workforce shortages). So, these doctors are reviewing paperwork or on the phone with auditors instead of seeing patients. They talk of claims that are caught up in years' long backlog and show me evidence that once an Administrative Law Judge reviews their claims, they prevail in the vast majority of cases. But for those years before an ALJ looks at their case, these hospitals don't get paid for services they have already provided, expenses they have already undertaken.

—How can HHS reduce and rectify problems identified with the RAC program?

—What can HHS do to reduce the burden on these providers that have a demonstrated record of honest billing while efficiently catching the bad actors the program was designed to go after?

Answer. The President's fiscal year 2016 budget request includes a proposal to allow prior authorization for Medicare fee-for-service items. Currently, CMS has authority to require prior authorization for certain Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) items. This proposal would extend that authority to all Medicare fee-for-service items, particularly those that are at the highest risk for improper payment. By allowing prior authorization on additional items, CMS can ensure that the correct payment goes to the right provider or supplier for the appropriate item, and prevent the need for targeted claims audits on those payments. Items that are reviewed through Prior Authorization would be excluded from Recovery Auditor reviews.

CMS has announced a number of future changes to the Recovery Audit Program in response to industry feedback. In the process of procuring new contracts, these changes will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency. A comprehensive list of the Recovery Auditor program improvements can be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf.

Question. The North Carolina Rural Health Research indicates that 47 rural hospitals have closed, or ceased providing inpatient services, since 2010. What is HRSA doing to track rural hospital closures, determine the reasons for these closures, and evaluate the impact these closures have on access to care in rural communities?

Answer. HRSA, through the Federal Office of Rural Health Policy (FORHP), has been tracking rural hospital risk and closure (or suspension of operations) for the past several years. From January 2010 through May 2015, 51 rural hospitals closed inpatient services. Thirty-three percent of those hospitals (17 of 51) were Critical Access Hospitals. To date, our analysis shows that it appears there are a variety of factors at work and there is no single common issue behind the closures. In communities where a hospital has closed, the response and remaining healthcare access varies widely. According to initial results, half of cases result in no healthcare services at that site following the hospital closure while in other communities, some type of healthcare continues. Remaining services after a closure vary and include outpatient care, primary care clinics, urgent care, skilled nursing, or physical therapy.

In collaboration with FORHP, the North Carolina Rural Health Research Program is conducting a study of closed hospitals and community impact. The first research brief from the study, "A Comparison of Closed Rural Hospitals and Perceived Impact" is available at https://www.ruralhealthresearch.org/alerts/67, and the ongoing hospital data collection for the project is at http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

Question. I would like to ask about an issue I have raised in previous HHS hearings over the past few years—the importance of Critical Access Hospitals and the proposed cuts to these hospitals contained in the President's 2016 budget request. Again, there are two specific changes proposed by the President's budget, reducing cost based reimbursement from 101 percent to 100 percent and changing the rules

to eliminate CAH designations for those hospitals within 10 miles of another hospital.

I am sure you are aware that rural hospitals across the country are struggling to remain open and financially viable. Since 2010, 50 hospitals have closed and 283 are on the brink of closure. Currently, nearly 38 percent of Critical Access Hospitals are operating at a loss. A study by Health Affairs shows that if these changes are implemented that percentage will double to more than 75 percent. At the same time, Critical Access Hospitals account for only 5 percent of Medicare inpatient and outpatient payments. So, these policy changes would result in relatively nominal budgetary savings, but come at a huge cost to rural patients and their communities.

—Given the serious challenges these polices would create for many rural hospitals, is the Administration concerned about how they would affect access to healthcare for Americans living in rural communities?

Answer. The proposals in the President's Budget proposal are carefully targeted to generate savings for the Medicare program without any significant adverse impact on rural access to care.

Limiting Critical Access Hospital designation to hospitals located within ten miles of the nearest hospital will ensure that only hospitals whose communities depend upon them for emergency and basic inpatient care will be designated as Critical Access Hospitals and receive reasonable cost-based reimbursement. CMS conducted an analysis on the impact of this proposal on access to services in rural communities.[2] Our analysis estimated that a maximum of 47 CAHs, out of a total of 1,339 certified CAHs, might be affected by this proposal. Moreover, facilities losing their CAH designation would not necessarily close. Instead, it is anticipated that many of these CAHs would continue to participate in Medicare as hospitals paid under the applicable prospective payment system, and would continue to provide hospital services to their communities without reliance on CAH designation. Hospitals that transitioned from their CAH status would be eligible for the Hospital Value-based Purchasing Program, which provides financial incentives for high quality of care and improvement in quality.

In the event that some of the potentially affected CAHs were to close, CMS analysis found that there likely is sufficient capacity in nearby facilities to provide the services any closed CAH had previously provided. CMS conducted an analysis of recent Medicare and cost report data for the potentially affected CAHs, as well as for the hospitals located within 10 miles of these CAHs. Overall, the data suggests that there would be no significant issues related to access to inpatient acute care services or skilled nursing services for the communities currently being served by the potentially affected CAHs should the CAH cease to provide services rather than convert its Medicare agreement to participate as a hospital. Additionally, HHS will continue to monitor rural communities to ensure that access to medical care is preserved.

The President's fiscal year 2016 Budget also proposes changing reimbursement of CAHs to pay them for their actual costs of providing care. This change would generate savings to the Medicare program while protecting access to care by reimbursing hospitals for 100 percent of their costs.

—Rural hospitals across the country, including those in Kansas, are facing an ever-increasing amount of Federal regulatory challenges—including meeting the direct supervision requirements for outpatient therapeutic services and keeping pace with their urban counterparts in meeting all of the requirements of the Medicare and Medicaid Electronic Health Care Record Incentive Programs. At the same time, the President has repeatedly called for cuts to Critical Access Hospitals in his budget requests, which are often one of the only sources of healthcare services in a community. Do you think your Department is doing all it can to make sure rural communities maintain access to necessary healthcare services that are vital to their survival and success?

Answer. As you know, being from a small town in West Virginia, rural health is an important priority for me. I am personally committed to and focused on supporting the health of rural communities.

CMS has a number of efforts to improve access to services for rural Medicare beneficiaries. CMS has rural health coordinators at each of our Regional Offices, who meet monthly with participation from CMS central office staff and the Health Resources and Services Administration (HRSA) to discuss emerging issues. Through the Rural Health Open Door Forum, CMS engages with stakeholders to provide current information on CMS programs, answer questions, and learn about emerging rural health issues. Through Medicare's telehealth benefit, Rural Health Clinics, and Critical Access Hospitals, CMS is making sure that rural beneficiaries have ac-

[2] Centers for Medicare and Medicare Services, Report on Critical Access Hospitals, March 26, 2015.

cess to physician and hospital services that may not otherwise be available in their communities. Moving forward, the Center for Medicare and Medicaid Innovation is testing new payment and delivery models such as Accountable Care Organizations (ACOs) with a focus on how to explore and support efforts to make further strides in improving the quality of care in rural areas.

The Administration's broad investment in rural health includes the $128 million request in the fiscal year 2016 President's Budget for HRSA's Federal Office of Rural Health Policy to maintain support for key programs and resources to assist rural communities. HRSA also supports nearly 1,300 health centers operating approximately 9,000 health center service sites across the country, and approximately 50 percent of them serve rural communities. A key focus of the Department is to increase access for rural Americans to a healthcare provider through health professional training programs. In fiscal year 2014, HRSA provided rural health exposure to students through 11,389 training sites in rural communities. In addition, HRSA's primary care, oral health, geriatrics, public health and behavioral health training grants supported 180,401 students from rural areas. The National Health Service Corps supports loan repayment and scholarships for primary care providers, with almost half of the participants serving in rural areas. As of September 30, 2014, 3,529 National Health Service Corps members, or 44 percent of the National Health Service Corps field strength, were working in rural communities and 75 NHSC clinicians were working at CAHs. Half of the nearly 5,000 active NHSC-approved sites are located in rural communities.

Rural communities have also benefited from the collaborative work of the White House Rural Council, which was created in July 2011. The Council is focused on enhancing the ability of Federal programs to serve rural communities through collaboration and coordination. For instance, through the work on the Council, HRSA expanded eligibility for the National Health Service Corps Program to CAHs in 2012. This resulted in 229 CAHs being designated as service sites for National Health Service Corps clinicians. Another result of the Council's effort is the leveraging of USDA loan programs to support health information technology in small rural hospitals. The Council also worked with CMS and HRSA to include a number of rural provisions in a Regulatory Burden Reduction regulation that take into account the unique practice environment for clinicians in rural areas; this regulation was finalized May 2014. Beyond encouraging collaborations among Federal agencies, the Council initiated a public-private partnership with approximately 50 private foundations and trusts that focus on improving rural healthcare.

—There is a clear push to move away from fee-for-service medicine and towards quality and value in healthcare. This transition requires hospitals to make up front investments in health equipment and technology. As we know, many Critical Access Hospitals operate on little to no margins, with limited resources to make capital investments. The cost based reimbursements these hospitals receive are essential to their operations budgets. How are these Critical Access Hospitals supposed to make these investments to facilitate future quality improvements when the Administration's proposals would mean more than three-fourths of these facilities would be operating at a loss?

Answer. Since their creation, CAHs have provided needed hospital services to millions of Medicare beneficiaries. CMS is committed to preserving the CAH program and believes in ensuring that CAHs provide quality care to isolated communities without another nearby source of acute inpatient and emergency care. Last year, CMS finalized a rule that included reforms to Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and other healthcare providers, which will save nearly $660 million annually, and $3.2 billion over 5 years. This rule specifically outlined ways to reduce burdens on rural healthcare providers. For example, a key provision reduces the burden on very small Critical Access Hospitals, as well as Rural Health Clinics and federally Qualified Health Centers, by eliminating the requirement that a physician be held to a prescriptive schedule for being onsite. This provision seeks to address the geographic barriers and remoteness of many rural facilities, and recognizes telehealth improvements and expansions that allow physicians to provide many types of care at lower costs, while maintaining high-quality care.

CMS appreciates the unique challenges that rural providers may confront as they move more towards quality and value. The Innovation Center is uniquely positioned to test and evaluate efforts to identify and address challenges to access and quality of care for rural communities. The Innovation Center is testing two models designed to support Accountable Care Organizations (ACOs) in rural areas. The Advance Payment ACO Model is meant to help entities such as smaller practices and rural providers with less access to capital participate in the Medicare Shared Savings Program. The ACO Investment Model is a new model of pre-paid shared savings that

builds on the experience with the Advance Payment Model to encourage new ACOs to form in rural and underserved areas and also plans to support existing ACOs that meet these criteria.

Question. The Affordable Care Act includes a provision that requires a Medicare beneficiary to have a face-to-face encounter with a physician who certifies the need for that beneficiary's Medicare home health services. I understand that this provision aims to make sure Medicare beneficiaries are accurately being referred to the proper care setting, while also reducing the potential for waste, fraud and abuse.

However, implementation of this face-to-face requirement has raised many concerns. The rules around what information physicians must document have been unclear and auditors who review the information have applied inconsistent and often conflicting standards on what is deemed "satisfactory." This has resulted in an unprecedented level of home health claim denials and a significant backlog of appeals. As this experience is extrapolated across the sector, I understand that we would expect the number of pending appeals to be in the thousands.

In a high percentage of cases, face-to-face claim denials are overturned on appeal. In the meantime, continued unpaid claims—for care that is otherwise medically necessary—are making it hard for smaller home healthcare providers, particularly those in rural and underserved areas, to meet payroll and keep their doors open.

—Does CMS have a plan to establish more consistent and uniform audits rules regarding home health claims?

Answer. CMS simplified the face-to-face encounter documentation requirements by eliminating the specific face-to-face narrative requirement, in order to reduce administrative burden, and provide home health agencies with additional flexibility. CMS will use documentation from the certifying physician's medical records, and/or the hospital or post-acute facility's medical records, for beneficiaries as the basis for certification of home health eligibility. This simplification was finalized after public comment in the Calendar Year 2015 Home Health Prospective Payment System final rule (79 FR 66031). The use of the template is voluntary and CMS believes the use of clinical templates may reduce burden on the physicians and practitioners who order home health services.

—In the meantime, how do you expect to reduce the home health backlog that has resulted from the problems associated with implementation of the face-to-face policy?

Answer. CMS plans to conduct outreach and education with physicians, Home Health Agencies, hospitals, post-acute facility discharge planners, and non-physician practitioners via Open Door Forum calls to discuss the draft clinical templates.

QUESTION SUBMITTED BY SENATOR THAD COCHRAN

Question. Mr. Cavanaugh, within the Health Care Innovation Awards program, the CMS Innovation Center has awarded funding to four projects that include Mississippi in their plans; however, of the more than $1 billion invested to date, there has not been a single grant awarded to support a program established by a Mississippi-based entity or applicant. Given what we have heard about the great advances in telehealth in Mississippi—much of which is certainly innovative and a test bed for new healthcare delivery models—why has CMS not directed funds towards any programs in my State? What could Mississippi do to strengthen applications for future funds to have a better opportunity for success?

Answer. The CMS Innovation Center has funded a wide range of programs in Mississippi that are working towards our delivery system goals of better care, smarter spending, and healthier people. These include the Strong Start for Mothers and Newborns Initiative (eight sites);[3] the Bundled Payments for Care Improvement Initiative (33 organizations);[4] the Advance Payment Accountable Care Organization (ACO) Model (one organization); and the Community-based Care Transitions Program (one organization) as well as work funded through the Health Care Innovation Awards.[5] Information about the Mississippi based participants in these programs is listed below.

The Health Care Innovation Awards model currently funds four projects with sites in Mississippi. The CMS Innovation Center received a large number of strong applications that were reviewed and ranked by independent panels, external to the Innovation Center. Applicants interested in understanding how review panels viewed the strengths and opportunities of their proposal may contact the CMS Inno-

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[3] http://innovation.cms.gov/initiatives/strong-start/.
[4] http://innovation.cms.gov/initiatives/bundled-payments/.
[5] http://innovation.cms.gov/initiatives/.Health-Care-Innovation-Awards/.

vation Center for additional information. Innovation Center staff will provide, upon request, summaries of reviewer comments to assist in developing successful future applications. Additionally, the Innovation Center assists applicants in developing successful proposals by conducting webinars and other forums to communicate program objectives and to respond to applicant questions.

In addition to HCIA, providers and stakeholders in Mississippi are participating in innovative efforts to make healthcare better across the State by participating in other Innovation Center models.

QUESTIONS SUBMITTED BY SENATOR LAMAR ALEXANDER

Question. The Health Resources and Services Administration (HRSA) is the Federal agency responsible for studying and addressing shortages in the supply of healthcare workers, which is critical to ensuring patients have access to quality healthcare.

How does HRSA use the data from healthcare provider projection reports to guide its healthcare workforce programs, especially the grant programs that are available to multiple types of providers?

Answer. The National Center for Health Workforce Analysis (NCHWA) collects and analyzes health workforce data and information in order to provide national and State policy makers, researchers, and the public with information on health workforce supply and demand. HRSA utilizes the information provided in NCHWA projection reports to assess changes in the national workforce which help guide the strategic direction of our programs. NCHWA also monitors workforce trends and makes that information available when assessing program performance data. Workforce projection reports are used to inform budget requests, formulation, program planning, and performance management, as appropriate.

HRSA's data show that demand for primary care services is projected to increase through 2020, due largely to aging and population growth and, to a much lesser extent, the expanded insurance coverage implemented under the Affordable Care Act. The demand for primary care physicians is expected to grow more rapidly than the physician supply, resulting in a projected shortage of approximately 20,400 full-time equivalent (FTE) physicians. The supply of nurse practitioners and physicians assistants, however, is projected to grow rapidly and could mitigate the projected shortage of physicians if these health professionals continue to be effectively integrated into the primary care delivery system.

The providers that are most needed in rural and underserved communities are primary care providers (physicians, nurse practitioners and physician assistants), mental and behavioral health providers, and oral health providers.

This data informed the Department's proposal for a four-part, $14.2 billion investment included in the fiscal year 2016 Budget to bolster the Nation's health workforce and to improve the delivery of care across the country. Two components of this initiative would fall within HRSA's purview—the establishment of the Targeted Support for Graduate Medical Education and the expansion of the National Health Service Corps. The Targeted Support for Graduate Medical Education program would be a competitive grant program that supports medical residency positions that advance key health workforce goals. A total of $5.25 billion in mandatory funding is requested for this program for fiscal years 2016—2025 to support an estimated 13,000 3-year medical residencies. The program would focus on training more physicians in primary care and understaffed specialties and encouraging physicians to practice in rural/underserved areas. While the Budget called for increased funding of NHSC, the extension of funding through the Medicare Access and CHIP Reauthorization of 2015 will allow NHSC to maintain a field strength of over 8,000. Through NHSC, HHS sends providers to high need areas across the country.

Question. HRSA's National Center for Health Workforce Analysis released a report in 2014 that found there are proportionally more EMTs, Paramedics, Licensed Practical Nurses, and healthcare aides in rural communities than in urban areas.

Are these providers being fully utilized in rural communities and what innovative models are being tested to utilize these providers to increase access to healthcare services and improve health outcomes in rural areas, while maintaining high standards for quality of care?

Answer. The National Center for Health Workforce Analysis 2014 report found there are proportionally more EMTs, Paramedics, Licensed Practical Nurses, and home healthcare aides in rural communities than in urban areas. Although utilization was not assessed in this report, distribution across and within urban and rural areas, along with State scope of practice requirements, may affect utilization patterns. For example, EMTs and Paramedics located in more rural area may deliver

additional services than those who are located in urban areas or in closer proximity to hospitals and medical centers. The Federal Office of Rural Health Policy has funded a 3-year demonstration project in the State of Montana to examine the use of community health workers in frontier communities. These non-clinical healthcare workers collaborate with providers in Critical Access Hospitals to improve care coordination for people who live in areas with limited healthcare services and to offer continuity and support mechanisms for these individuals in order to manage chronic health conditions that often lead to avoidable hospitalizations and readmissions. A formal evaluation of this project will be completed in the fall of 2015.

QUESTION SUBMITTED BY SENATOR SHELLEY MOORE CAPITO

Question. West Virginia has 20 critical access hospitals that each play a vital role in providing emergency healthcare services in their local communities. These hospitals are also important to the local economy of the communities they serve. Many of these hospitals could not survive as prospective payment system (PPS) facilities.

The 2013 HHS Inspector General's recommendation calling for a reassessment of hospitals' eligibility for critical access status caused a tremendous amount of concern among these smaller rural hospitals in my State. The Administration's budget proposal does not adopt the IG's recommendation—and I appreciate that—but you do seek to eliminate critical access status for hospitals within 10 miles of another hospital. You estimated in your testimony that would impact a maximum of 47 hospitals. Do you view that budget provision as the end of your effort to reexamine eligibility for critical access hospitals or do you expect to recommend additional changes in the future? Can you commit that the Administration does not intend to seek legal authority to implement the IG recommendation?

Answer. The proposals in the President's Budget proposal are carefully targeted to generate savings for the Medicare program without any significant adverse impact on rural access to care. Limiting Critical Access Hospital designation to hospitals located within ten miles of the nearest hospital will ensure that only hospitals whose communities depend upon them for emergency and basic inpatient care will be designated as Critical Access Hospitals and receive reasonable cost-based reimbursement.

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

Question. Community health centers are essential to increasing access to primary care for America's most vulnerable and rural populations. Last week, HHS announced that it will award $100 million to create 160 new health centers that are projected to increase access for 650,000 patients. This includes funding for two new rural clinics in Port Angeles and Okanogan in my State of Washington (WA). It builds on the 550 new health centers we have helped fund since the Affordable Care Act went into effect. How many of these new centers are in rural communities? When awarding new health center grants, how does HRSA work to ensure it is measuring and increasing access to care in rural areas? What percentage of the new clinics created since 2009 utilize telemedicine, and what is the Department doing to increase that figure?

Answer. Per section 330 of the Public Health Service Act, HRSA is required to award grants such that no more than 60 percent and no fewer than 40 percent of total grants awarded serve people from rural areas. In order to ensure this distribution, HRSA may award grants to applications out of rank order. Seventy-four (45 percent) of the 164 new access point awardees announced in May 2015 serve rural communities, and these rural health center sites are expected to increase access to an additional 235,000 patients.

HRSA's Bureau of Primary Health Care (BPHC) encourages health centers to provide all health center services in ways that maximize access and best meet the needs of their service area and target population, which may include telemedicine; however, BPHCBPHC does not collect data on the number of new access point sites that provide services through telemedicine. Several rural community health centers are connected to telehealth networks funded by the Federal Office of Rural Health Policy's Office for Advancement of Telehealth.

Question. Washington State has significantly expanded coverage and reduced costs through the creation of a State-based health insurance exchange and the expansion of Medicaid. These changes have had positive effects for both urban and rural communities throughout the State. Recent data shows that percentage of WA uninsured residents have dropped by 7 percent since the implementation of the ACA, and that Medicaid expansion saved the State over $100 million last year.

Please describe the impact of the Affordable Care Act on our Nation's rural healthcare system? Please describe the national trends in uncompensated care and patient loads, and what the impact has been in rural America? We know that over 30 rural hospitals have closed since 2013. Please describe some of the factors that are driving these closures?

Answer. The Affordable Care Act (ACA) is making health coverage affordable and accessible for millions of Americans. For the nearly 50 million Americans living in rural areas, the law addresses inequities in the availability of healthcare services; increases access to quality, affordable health coverage; invests in prevention and wellness; and gives individuals and families more control over their healthcare. Uninsured individuals living in rural areas are able to use the Marketplaces, a government agency or a non-profit organization in each participating State, to compare qualified health plan insurance options based on price, benefits, quality, and other factors with a clear picture of premiums and cost-sharing amounts to help them choose the qualified health insurance plan that best fits their needs. Each insurance plan offered through the Marketplaces covers essential health benefits, including prescription drugs, inpatient and emergency services, pediatric care, and behavioral health treatment.

The ACA has resulted in a decrease in the uninsured rates in both rural and urban areas. According to a recent Urban Institute Study, the share of uninsured adults in rural areas has decreased one-third to 14.4 percent from the first ACA open enrollment period to March 2015. There was a 36.6 percent decrease to nearly 11 percent in rate of uninsured in urban areas.

From January 2010 through May 2015, 51 rural hospitals closed inpatient services. To date, our analysis shows that it appears there are a variety of factors at work and there is no single common issue behind the closures. We will continue to monitor this.

QUESTIONS SUBMITTED BY SENATOR BRIAN SCHATZ

Question. Mr. Cavanaugh, 2 weeks ago in this subcommittee we had a hearing on the fiscal year 2016 HHS budget. In that hearing, Secretary Burwell and I discussed where HHS can facilitate expanded use of telehealth within current statutory authority. She mentioned the Innovation Center and ACOs as areas where CMS could do more for telehealth.

My understanding is that the CMS Innovation Center can waive Medicare restrictions on telehealth for various initiatives and experiments. In the Next Generation ACO program, CMS waived the statutory 1834(m) restrictions on geographic location and where the patient can be located during telehealth visits. However, CMS did not lift certain restrictions, including use of store-and-forward technologies and ability for occupational and speech therapists to use telehealth for their services.

Can you please address how the Innovation Center might help to further expand telehealth services? Are there other opportunities in the Innovation Center or other CMS areas where telehealth could be expanded within your statutory authority?

Answer. The telehealth waiver in the Next Generation ACO Model addressed the originating site requirement, which was the barrier most often cited by commenters in response to CMS' Request for Information on this payment policy. CMS remains open to exploring waivers of additional elements of payment for telehealth services in later years of the Next Generation Model and/or in other Innovation Center models.

Question. Mr. Cavanaugh, you discussed statutory provisions on telehealth that, in my opinion, limit access to care. For example, requiring a patient to be at a designated originating site—versus at home, or elsewhere—and not allowing for store-and-forward technologies in most States, are barriers to telehealth expansion.

If we take legislative action on telehealth, what provisions would you like to see included to allow telehealth to expand for Medicare beneficiaries?

Answer. We share your interest in using telehealth to expand access to specialized services that may not otherwise be available at facilities in some rural areas. Medicare payment for telehealth services is prescribed in section 1834(m) of the Social Security Act. According to the statute, Medicare pays for telehealth services that are furnished via a telecommunications system, by a physician or practitioner, to an eligible telehealth individual, where the physician or practitioner providing the service is not at the same location as the beneficiary. A variety of practitioners are authorized as telehealth practitioners, including physicians, physician assistants, and nurse practitioners. Currently, 75 codes are covered as telehealth services under Medicare. The statute permits the Secretary to pay for other telehealth services

which are considered through the annual physician fee schedule rulemaking process.

In addition to Medicare payment for telehealth services as prescribed by statute, telehealth is a component of various initiatives currently being tested by the Centers for Medicare and Medicaid Innovation. These demonstrations could inform future Medicare policy changes and we would be happy to discuss them with you further. For example, under the Health Care Innovation Awards initiative HealthLinkNow, Inc. is pairing aspects of telemedicine and telephyschiatry, with virtual care navigators and behavioral health specialists, to serve patients with a variety of chronic mental and behavioral health conditions in frontier and rural communities in Wyoming, Montana and Washington State. Also, organizations participating in the Bundled Payments for Care Improvement Initiative are eligible to waive some of the geographic restrictions so that they can bill for telemedicine services and receive Medicare fee-for-service payments. The Innovation Center's work may help us better understand the potential value of telehealth for improving the quality of care and reducing expenditures.

Question. Mr. Morris, thank you for your words on expanding telehealth usage. Hawaii has an active Pacific Basin Telehealth Resource Center funded by HRSA, which is an important asset for our State. I am also interested in HRSA's use of telehealth to improve access to and coordination of mental health services in rural areas. I have supported a HRSA program to increase the behavioral health workforce through the president's Now is the Time Initiative with SAMHSA.

Would these increased funds be utilized, at least in part, to expand tele-mental health use?

Answer. Yes. HRSA and SAMHSA are collaborating on the Behavioral Health Workforce Education and Training (BHWET) grant program in support of the Now is the Time Initiative. This grant program was funded in fiscal year 2012 for 3 years through SAMSHA's Prevention and Public Health Fund. This program aims to expand the behavioral health workforce serving children, adolescents, and transitional-age youth at risk for developing or who have developed a recognized behavioral health disorder. BHWET grantees support education and training to increase the numbers of adequately prepared behavioral health professionals and paraprofessionals working with at-risk children, youth and their families, and may include tele-mental health. For example, Southwest Virginia Community College, Cedar Bluff, VA leverages relationships with community partners and support programs to ensure the academic success of program participants, to facilitate internships with a focus on at-risk and transitional youth, and to enhance job placements. One of their key partnerships that utilizes tele-health services is Cumberland Mountain Community Services (CMCS), a State funded counseling center with satellite offices in each of the four county services regions. CMCS offers individual, family and group counseling services with specialized services for substance abuse counseling, domestic violence, and behavioral disorders. The center also serves as a tele-health site for the diagnosis and treatment of behavioral health disorders. CMCS also serves as a mental health services provider for the county court systems and the probation and parole offices in the service region.

CONCLUSION OF HEARING

Senator BLUNT. We thank our panel for coming, and we are going to adjourn until 10 a.m. on Thursday, May 16th.

Thank you all for being here.

Thank you, all.

[Whereupon, at 11:50 a.m., Thursday, May 7, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]